FINANCIAL SERVICES COMMISSION
Office of Insurance Regulation
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June 14, 2017

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

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

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

ITEM	SUBJECT	RECOMMENDATION

1. Minutes of the Financial Services Commission for March 14, 2017.

   http://www.myflorida.com/myflorida/cabinet/agenda17/0314/transcript.pdf

   (ATTACHMENT 1) **FOR APPROVAL**

2. Request for Approval for Final Adoption of Repeal of Rule 69O-128.025; Confidentiality of Personal Financial and Health Information.

   Section 624.23, F. S. defines "personal financial and health information".

   The rule should be repealed due to conflict with statutory definition.

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

3. Request for Approval for Final Adoption of Rules 69O-137.001 and 69O-138.001.

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

NAIC Annual Statement Instructions Manuals, and the 2015 and 2016 NAIC Accounting Practices and Procedures Manuals.

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

(ATTACHMENT 3) **APPROVAL FOR FINAL ADOPTION**

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

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

(ATTACHMENT 4) **APPROVAL FOR FINAL ADOPTION**

5. Request for Approval for Final Adoption of Repeal of Rules 69O-167.015, 69O-171.004, 69O-176.022, 69O-185.007, 69O-189.007.

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

(ATTACHMENT 5) **APPROVAL FOR FINAL ADOPTION**

6. Request for Approval for Publication of Repeal of Rule 69O-125.002; Unfair Discrimination in Insurance Rates-Multi-Policy Discounts

   This rule has become obsolete due to changes in the law governing the approval of multi-policy discounts. Section 627.0655, F.S. as amended, now has codified the contents of the rule and accordingly the rule is no longer necessary.

(ATTACHMENT 6) **APPROVAL FOR PUBLICATION**

7. Request for Approval for Publication of Repeal of Rules 69O-136.002,.006: Foreign and Alien Insurers Filing for a Certificate of Authority; Domestic Insurers Filing for an Application for Permit

   These two rules are being repealed as a part of reorganizing and streamlining the application process governed by Rule Chapter 136, F.A.C.

(ATTACHMENT 7) **APPROVAL FOR PUBLICATION**

8. Request for Approval for Publication of Rule 69O-136.004,.005,.012,.018,.031,.032 and .034: Application procedures for Companies Seeking to Do Business in Florida"- Electronic Filing Rules

   Chapters 624, 625, 628, 629 and 632, Florida Statutes, provide authority for the Office to issue Certificates of Authority and licenses to insurers and related entities. Rule Chapter 69O-136 adopts the necessary forms to be used and governs the filing process. The rules are amended to provide for electronic filing and update the rules to adopt the forms which are currently in use by the Office. Rules 69O-136.002 and 69O-136.006 are being repealed due to reorganizing and streamlining the rule chapter.

(ATTACHMENT 8) **APPROVAL FOR PUBLICATION**

9. Office of Insurance Regulation Commissioner Performance Evaluation and Leadership Assessment.

(ATTACHMENT 9) **FOR APPROVAL**

OFFICE OF INSURANCE REGULATION

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

COMMISSIONER ALTMAIER: Good morning, Governor.

GOVERNOR SCOTT: Good morning.

COMMISSIONER ALTMAIER: Good morning, members of the Cabinet. It's good to be back. We will get right to it.

The first item on our agenda is the adoption of the minutes of the December 6th Financial Service Commission meeting. So I would respectfully request --

GOVERNOR SCOTT: Is there a motion on the item?

ATTORNEY GENERAL BONDI: So move.

CFO ATWATER: Second.

GOVERNOR SCOTT: Any comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

Item Number 2 is a request for the approval of

final adoption of the repeal of several rules. There are seven: 69P-5.002 all the way through 012. These are rules related to surplus lines tax collection, which is now overseen by the Florida Surplus Lines Office, so these rules are obsolete.

We did publish those. The last time that I appeared here I went through the process of the rules and now respectfully request your approval for final adoption.

GOVERNOR SCOTT: Is there a motion on the item?

ATTORNEY GENERAL BONDI: So moved.

CFO ATWATER: Second.

GOVERNOR SCOTT: Any comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

The third agenda item is the request for approval for the publication of the repeal of Rule 690-128.025. We are proposing to repeal this rule because this is now a definition found in Florida Statutes. It is -- the statutory definition conflicts with the rule, so the rule is obsolete and should be repealed. So we'd

respectfully request your permission to publish that.

GOVERNOR SCOTT: Is there a motion on the item?

ATTORNEY GENERAL BONDI: So move.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

The fourth agenda item is request approval for publication for Rule 690-137.001, and 690-138.001. These are rules that adopt the various accounting manuals and accounting guidance and examination processes that our team goes through and that the insurance companies file with the Office. There are typically some very technical changes that are made to these manuals.

The specific year editions are adopted in the rule, and so every year we bring these rules for the publication process so that we can get the most up-to-date information into the rules. And so that is what is being changed here. So I'd respectfully

request your permission -- your approval to publish those.

GOVERNOR SCOTT: Go ahead and do 5 and 6, so -- we can do them all together.

COMMISSIONER ALTMAIER: Okay. Absolutely.

So Number 5 is a request to publish -- hopefully you won't make me read all of those. There are a substantial number of rules in this particular agenda item.

What we're attempting to do here, the vast majority, if not all, of our filings made with the Office are now done electronically. The rules don't reflect those electronic filing processes, and so we have identified every rule related to making a filing with the Office, as well as related to how insurance companies and other interested parties obtain those rules from the Office.

The rule still reflects the process of actually hand delivering them, or mailing them to us, or coming to the Office and collecting those, as opposed to the process now, which is visiting our website to obtain the forms or to file those electronically. So we are requesting approval to publish those changes.

And then, finally, at the bottom, Agenda Item

Number 6, there are several rules that we have identified that cover various number of items that are now obsolete, either due to statutory changes related to the rulemaking authority or a different agency covering those processes.

So Item 4, request for approval of the publication of amendments to those rules.

Agenda Item Number 5, request for publication for amendments to those rules related to our new electronic filing process.

And Number 6, approval for publication to repeal that set of rules.

GOVERNOR SCOTT: Is there a motion on Items 4, 5, and 6?

CFO ATWATER: So moved.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the three items pass.

COMMISSIONER ALTMAIER: All right. Thank you very much.

So we'll get to our last agenda item, which is an update on our quarterly report, as well as some

things we've been up to since the last time that we talked, so we will just jump right into it.

I'm pleased to report that our second quarter scores were an improvement on our first quarter scores. We averaged a 4.86 on our metrics.

I will mention Metrics 6, 7, and 8, I think we've discussed those previously. Those are related to our financial examination process. That's a process that takes up to 18 months to complete.

And so through the -- through December of 2016, we had not completed any examination to date because we had not been working on them for that long. But since December, we have already completed a number of financial examinations; and so the third quarter report will reflect actual scores for those items.

So I'll pause just for a moment to see if there are any questions on this particular slide before we move on.

GOVERNOR SCOTT: No. Go ahead.

COMMISSIONER ALTMAIER: Thank you.

I did want to give a brief update on Hurricane Hermine and Hurricane Matthew. We have continued to collect information about the claims

that our insurance companies have reported on these.

You can see Hermine's estimated insured losses are 139 million; for Matthew, 1.18 billion in estimated insured losses.

As we've stated previously, we continue to believe that these numbers will not significantly stress the financial condition of the insurance companies that are operating in our marketplace. This is normal development since the last time that we've been here with respect to the closing out of those claims.

The percentage of claims closed is also something that we're not troubled by. We believe that there are -- we've not seen any consumer complaints related to insurance companies that are taking too long to get to homes or denying claims or things of that nature. We'll continue to monitor that to make sure that insurance companies are out finishing up the claims that they're responsible for.

A couple of activities that we've done on the P & C side, it's been a relatively light quarter for us. We did issue a couple of statutory required reports. They are both on this page with

a couple of highlights from each one of them.

We issued the 2016 medical malpractice report, as well as the 2016 workers' compensation report. Nothing significant from either report with the exception of the workers' comp reports. Of course it did highlight some of the uncertainty that the markets will likely be facing in the near future as it relates to the Castellanos' decision, as well as some other Supreme Court decisions that came out last spring.

On the life and health side, we've been a little bit more active. There are a couple of different issues on this page. The right-hand side of the life insurer solvency issue is the implementation of the new principles base reserving, which will go into effect for the first time during 2017.

This is an item that life insurance companies have been working on for some time from an implementation standpoint. So we continue to work with them as we expect to see the first year of results under the new PBR regime this year.

Nothing concerning from the Freedom to Travel Report. The Freedom to Travel Report is, of course, a report on life insurance companies

that potentially deny coverage to individuals based on their intentions to travel to foreign countries. And so every year we do a report to make sure that companies are not doing that inappropriately, and we had very, very minimal self-reported complaints on that side.

I do want to spend just a moment talking about some activity we've had on the long-term care side. This is a subject that we've discussed with the Cabinet on a few different occasions.

We have made, in my opinion, some innovative and productive strides since the last time we spoke with respect to long-term care. Just as background, we've discussed the significant need for rate increases that these long-term care companies have had, in some cases over, 100% rate needs.

It's been a very difficult balance to strike between making sure that those products and those companies remain viable, versus making sure that consumers aren't faced with paying those significant rate increases. Oftentimes, these are consumers that have had the product for 20 to 30 years, are now on fixed incomes, and it's very difficult for them to come up with the extra

premium.

So we have been negotiating with the companies. We have devised what I believe is the first of its kind approach to where we have worked with the companies to break up the rate increase over a period of years, and so instead of implementing it all at once so consumers get hit with it all at the same time, we've implemented the rate increases over a period of three years, and then requested rate guarantees from the insurance companies so that we won't see any additional rate increases for up to ten years after that.

And so this will, I think, marry very well the need for these companies to have the rates in place, as well as protecting consumers and giving them a little bit of certainty and ability to plan for these pending rate increases. And so I'm very proud of our team for coming up with this solution. I think we've worked very hard on that one.

So just a brief update on the legislative agenda which dovetails nicely with that. As you recall, the last time we were here, we had four items on our legislative agenda. One of them was an attempt to address some of those long-term care issues that I just raised. We've had a number of

conversations with various stakeholders about legislative ideas that we had with respect to long-term care.

Some of the concerns that were raised about our ideas, coupled with the fact that we have already made significant strides in addressing some of the rate issues with the administrative rate approvals. We believe that it would be appropriate for us to continue having the conversation with the stakeholders about long-term care, but perhaps focus on our other three legislative agenda items that you see here, and leave long-term care for perhaps another legislative session.

And so that would leave us with our assignment of benefits issues, our continuing care retirement community issue, and our HMO solvency issue, all three of which we continue to work very closely with the various stakeholders and the members of the Legislature to advance meaningful reform in those three areas.

And that wraps it up, so I'd be happy to take any questions that there might be.

GOVERNOR SCOTT: Does anybody have any questions?

CFO ATWATER: No.

GOVERNOR SCOTT: All right.

COMMISSIONER PUTNAM: Good report.

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

ATTORNEY GENERAL BONDI: So move.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

Thank you, David.

COMMISSIONER ALTMAIER: Thank you very much.

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M E M O R A N D U M

DATE: May 16, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for June 14, 2017
Request for Final Approval to Adopt Repeal of
Rule 69O-128.025
Assignment # 199866-16

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before June 7, 2017 and to the Financial Services Commission on June 14, 2017, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on May 18, 2017.

The notice of proposed rules was published on March 20, 2017 in Volume 43, No. 54, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

The rule is being repealed because it is inconsistent with the definition provided in the statute.

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

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

Stephen Fredrickson 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-128.025 Confidentiality of Personal Financial and Health Information Pursuant to Section 624.23, F.S.

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

69O-128.025 Rulemaking Authority

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

624.23 Public records exemption.—

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

(a) "Consumer" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The National Association of Insurance Commissioners.

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

624.307 General powers; duties.—

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

M E M O R A N D U M

DATE: May 16, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for June 14, 2017
Request for Final Approval to Adopt Amendments to
Rule 69O-137.001
Assignment # 203211

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before June 7, 2017 and to the Financial Services Commission on June 14, 2017, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on May 18, 2017.

The notice of proposed rules was published on March 20, 2017 in Volume 43, No. 54, of the *Register.* The hearing was not requested, therefore, the hearing was not held.

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

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

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

Stephen Fredrickson 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

M E M O R A N D U M

DATE: May 16, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for June 14, 2017
Request for Final Approval to Adopt Amendments to
Rule 69O-138.001
Assignment # 203213-17

The Office of Insurance Regulation requests that these proposed amendments be presented to the Cabinet aides on or before June 7, 2017 and to the Financial Services Commission on June 14, 2017, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on May 18, 2017.

The notice of proposed rules was published on March 20, 2017 in Volume 43, No. 54, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

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

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

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

Stephen Fredrickson 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) thru (3)(a) No Change

(b)1. The National Association of Insurance Commissioners electronic transmission filing instructions (Financial Internet Filing Online User's Guide 2017 ~~2016~~) are hereby adopted and incorporated by reference, https://www.flrules.org/Gateway/reference.asp?No=Ref-05718.

2. 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, 2016 ~~2015~~;

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

3. The NAIC's Annual Statement Instructions, Health, 2016 ~~2015;~~

4. The NAIC's Annual Statement Instructions, Title, 2016 ~~2015~~; and,

5. The NAIC's Accounting Practices and Procedures Manual, as of March 2016 ~~2015~~.

(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, 2017 ~~2016~~;

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

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

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

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

(c) Copies of the manuals are available:

1. and 2. 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 Amended_____.

69O-138.001 NAIC Financial Condition Examiners Handbook Adopted.

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

(b) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 2016 ~~2015~~ is hereby adopted and incorporated by reference.

(2) and (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 Amended_____.

624.308 Rules.--

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

624.424 Annual statement and other information.--

(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing of an annual or quarterly statement. The statements shall contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally utilized by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form for financial statements approved by the National Association of Insurance Commissioners in 2002, and may adopt subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office or such organization as the office may designate all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

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

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

69O-138.001
Statutory Authority

624.308 Rules.--

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

624.316 Examination of insurers.–

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

M E M O R A N D U M

DATE: May 17, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for June 14, 2017
Request for Final Approval to Adopt Amendments to
Rules for Electronic Filing Life and Health
Assignment # 199194-16

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before June 7, 2017 and to the Financial Services Commission on June 14, 2017, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on May 18, 2017.

The notice of proposed rules was published March 20, 2017 in Volume 43, No. 54, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

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

Sections 624.308(1), 624.307, 627.6699, 624.424, 627.6475, 627.6692(9)(5), 627.674, 641.36, 627.307,627.410, 627.6425, 627.6487(9),627.6571, 641.31074, 627.673, 627.6735, 627.6741, 627.6745, 627.6746, 627.6785, 627.682, 641.31, 641.36, 627.413(4), 627.4145, F.S., provide rulemaking authority and laws implemented for these rules.

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

Stephen Fredrickson 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

M E M O R A N D U M

DATE: May 26, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for June 14, 2017
Request for Final Approval to Adopt Amendments to
Rules for Electronic Filing Property and Casualty Product Review
Assignment # 199194-16

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before June 7, 2017 and to the Financial Services Commission on June 14, 2017, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on May 18, 2017.

The notice of proposed rules was published on March 20, 2017 in Volume 43, No. 54, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

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

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

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

Stephen Fredrickson 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

M E M O R A N D U M

DATE: May 31, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for June 14, 2017
Request for Final Approval to Adopt Amendments to
Rules for Electronic Filing Property and Casualty Financial Oversight
Assignment # 199194-16

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before June 7, 2017 and to the Financial Services Commission on June 14, 2017, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on May 18, 2017.

The notice of proposed rules was published on March 20, 2017 in Volume 43, No. 54, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

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

Sections 624.308(1), 624.4085,624.4243, 624.424(8)(e),(10), 624.307(1), 624.324, 624.610(11), 624.316, 624.3161, 624.320. 624.321(1), 624.424, 625.212(3), 625.331, 624.80, 624.81, 625.012, 625.172, 625.302, 625.330, 625.332, 625.338, 624.610, F.S., provide rulemaking authority and laws implemented for these rules.

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

Stephen Fredrickson 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

M E M O R A N D U M

DATE: May 17, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for June 14, 2017
Request for Final Approval to Adopt Amendments to
Rules for Electronic Filing Market Investigations
Assignment #199194-16

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before June 7, 2017 and to the Financial Services Commission on June 14, 2017, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on May 18, 2017.

The notice of proposed rules was published on March 20, 2017 in Volume 43, No. 54, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

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

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

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

Stephen Fredrickson 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-203.042 Filing, Approval of Subscriber Contract and Related Forms.

(1) through (2) No change

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

(a) through (e) No change

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

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

69O-203.045 Rates.

(1) through (2) No change

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

(4) through (8) No Change

(9) Filings shall be submitted electronically to http://www.floir.com/iportal. ~~mailed to: Office of Insurance Regulation, Division of Insurer Services, Bureau of Life and Health Forms and Rates, Post Office Box 8040,~~

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

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

69O-203.100 Prescribed Forms.

The forms listed below are incorporated herein, and made a part of, these rules by reference:

Title	Form Number
(1) Application for Certificate of Authority Prepaid Limited Health Service Organization	OIR-C1-1119 (12/05) ~~(8/94)~~
~~(2) Invoice – Request for Payment of Application Fees~~	~~OIR-C1-111920 (12/05) (7/93)~~
(2 ~~3~~) Invoice – Request for Payment of Fingerprint Charges	OIR-C1-903 (12/05) ~~(1/94)~~
(3 4) Biographical ~~Statement and~~ Affidavit	OIR-C1-1423~~422~~ (8/14) ~~(11/90)~~
~~(5) Abbreviated Biographical Statement~~	~~OIR-449 (5/89)~~
(4~~6~~) Authority for Release of Information	OIR-C1-450 (5/00)~~(8/91)~~
(5~~7~~) Service of Process Consent and Agreement	OIR-C1-144 (06/04)~~(11/90)~~
(6~~8~~) Instructions for Furnishing Background Investigative Reports	OIR-C1-905 (2/15)~~(8/93)~~
(7~~9~~) Fingerprint Card Instructions	OIR-C1-938 (5/13)~~(4/91)~~
(8~~10~~) Statement of Acquisition ~~Application~~ merger of Consolidation of a Specialty Insurer	OIR-C1-448

Pursuant to Florida Statutes 628.461, 628.4615	(12/05)~~(5/89)~~
~~(11) Annual Report~~	~~OIR-1131 (1/94)~~
~~(12) Annual Report Supplement~~	~~OIR-1132 (1/94)~~
~~(13) Quarterly Report~~	~~OIR-1136 (1/94)~~
(9) Annual Report Supplement - Contracts Issued and Outstanding	OIR-A2-949 (07/04)
(10) Annual Report Supplement – Damage Claims & Medical Injury	OIR-A2-950 (07/04)

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

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

69O-203.210 Forms Incorporated by Reference.

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

(a) The following forms which are hereby adopted:

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

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

	FORM #	TITLE
1.	OIR-C1 ~~DI4~~-144	SERVICE OF PROCESS CONSENT & AGREEMENT

2. OIR-C1-903 INVOICE REQUEST FOR PAYMENT OF FINGERPRINT CHARGES

3. OIR-C1-938 FINGERPRINT CARD INSTRUCTIONS

4. OIR-C1-1298 MANAGEMENT INFORMATION FORM COMPLETE LIST OF OFFICERS, DIRECTORS, AND SHAREHOLDERS (10% OR MORE)

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

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

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

69O-154.114 Withdrawal From the Individual Market.

(1) through (7) No change

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

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

69O-154.115 Designation of Election to Become a Risk-Assuming or Reinsuring Carrier.

(1)(a) No change

(b) The individual issuer desiring to be a risk-assuming or reinsuring carrier shall use Form OIR-B2-1311 (rev. ~~10/98~~ 8/03), State of Florida/Individual Carrier's Application to Become a Risk Assuming Carrier or a Reinsuring Carrier, which is hereby adopted and incorporated and may be obtained from the Office's website: http://www.floir.com/iportal ~~Bureau of Life and Health Forms & Rates, 200 East Gaines Street, Tallahassee, Florida 32399-0328~~, as required by Section 627.6475(5), F.S.

(2) through (3) No change.

Rulemaking Authority 624.308, 627.6475(9) FS. Law Implemented 624.307(1), 624.424, 627.6475, 627.6487(9) FS. History–New 9-19-00, Formerly 4-154.115 Amended _____.

69O-154.305 Election and Premium Notice Form.

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

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

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

69O-154.410 Withdrawal From the Group Market.

(1) through (7) No change

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

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

69O-154.512 Withdrawal From the Small Group Market.

(1) through (7) No change

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

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

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

(1) through (3) No change

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

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

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

(1) through (2) No change

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

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

69O-202.015 Forms Incorporated by Reference.

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

Title	Form Number
(a) Notification to the ~~Florida~~ Office of Insurance Regulation as a Qualifying Issuer of Donor Annuity Agreements Pursuant to Section 627.481, Florida Statutes	OIR-C1-1208 (rev. 01/17 ~~07/03~~)
(b) Sworn Statement in Lieu of Annual Statements For Issuers of Donor Annuity Agreements	OIR-A3-1209 (rev.01/17 ~~07/03~~)

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

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.424, 624.307(1), 627.481 FS. History–New 7-15-90, Formerly 4-117.015, Amended 6-23-92, 1-7-97, 12-24-03, Formerly 4-202.015 Amended _____.

69O-192.058 Forms Incorporated by Reference.

The following forms are incorporated into this rule chapter by reference to implement the provisions of Sections 624.436 through 624.446 ~~45~~, F.S.:

Title	Form Number
(1) Application for Certificate of Authority ~~as a~~ Multiple Employer Welfare Arrangements	OIR-C1-983 http://www.flrules.org/Gateway/reference.asp?No=Ref-08304 ~~(4/95)486 (10/93)~~ ~~OIR-C1-983 (4/95)486 (10/93)~~
~~(2) Application Cover letter~~	
(2)~~(3)~~ Application For Certificate of Authority Multiple Employer Welfare Arrangement Instructions	OIR-C1-984 http://www.flrules.org/Gateway/reference.asp?No=Ref-08305 (11/04) ~~(10/93)~~
(3)~~(4)~~ Application For Certificate of Authority Multiple Employer Welfare Arrangement Checklist	OIR-C1-985 http://www.flrules.org/Gateway/reference.asp?No=Ref-08303 (11/04) ~~(10/93)~~
(4)~~(5)~~ Invoice	OIR-C1-980 (10/93)
(5)~~(6)~~ Management Information	OIR-C1-844 http://www.flrules.org/Gateway/

	reference.asp?N o=Ref-08288 (4/97) ~~(10/91)~~
(6) ~~(7)~~ Instructions for Furnishing Background Investigative Reports	OIR-C1-905 http://www.flrul es.org/Gateway/ reference.asp?N o=Ref-08301~~939~~ ~~(08/93)~~ (2/15)
(7) ~~(8)~~ Annual Statement	OIR-487 (4/89)
(8)~~(9)~~ Statement of Net Assets	OIR-488 (5/89)
(9) ~~(10)~~ Statement of Change in Net Assets	OIR-489 (5/89)
(10) ~~(11)~~ Authority For ~~to~~ Release of Information	OIR-C1-450 http://www.flrul es.org/Gateway/ reference.asp?N o=Ref-08301 (5/00) ~~(8/91)~~
(11)~~(12)~~ Biographical Statement and Affidavit	OIR-C1-422 http://www.flrul es.org/Gateway/ reference.asp?N o=Ref-08287 (10/26/98)~~(11/90)~~
(12) ~~(13)~~ Statement of Acquisition Merger or Consolidation of a Specialty Insurer	OIR-C1-448 ~~(12/91)~~ (12/05)
(13)~~(14)~~ Fingerprint Payment and Submission Procedure	OIR-C1-938 (5/2013)

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

Rulemaking ~~Specific~~ Authority 624.4431 FS. Law Implemented 624.424, 624.439, 624.442, 628.4615 FS. History–New 7-15-90, Formerly 4-116.015, Amended 7-28-94, Formerly 4-192.058 Amended_____.

69O-138.005 Exams By Non Employees.

(1) No change

(2) Section 624.316(2)(b), F.S., requires the Office to examine each insurer applying for an initial Certificate of Authority to transact business in this state before granting the initial certificate. For purposes of this provision, ~~for examinations commenced on or after January 1, 1994,~~ the Office will, in the absence of a reasonable belief that the examination report is not accurate, accept the examination report of a foreign insurer as prepared by the insurance office of the insurer's domiciliary state if the domiciliary insurance office is accredited by the National Association of Insurance Commissioners in the area of financial regulation or if the examination is performed under the supervision of or with the participation of an examiner from a state which is so accredited and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their Insurance Office.

(3) Section 624.316(2)(c), F.S., permits the Office, in lieu of making its own examination of a foreign insurer, to accept a full report of the most recent examination of a foreign insurer, as certified to by the insurance supervisory official of another state. For purposes of this provision, ~~for examinations commenced on or after January 1, 1994,~~ the Office will, in the absence of a reasonable belief that the examination report is not accurate, accept the examination report of a foreign insurer as prepared by the insurance office of the insurer's domiciliary state if the domiciliary insurance office is accredited by the National Association of Insurance Commissioners in the area of financial regulation or if the examination is performed under the supervision of or with the participation of an examiner from a state which is so accredited and who, after a review of the examination work papers and report, states under oath that the examination was performed in a manner consistent with the standards and procedures required by that Insurance Office. Such reports of examination must be certified to by the insurance supervisory official of the state of domicile and mailed to the Office within 10 calendar days of receipt by the insurer, except that, if the report shows that the insurer has materially misstated its financial condition or that the insurer does not meet the minimum capital and surplus requirements of the Florida Insurance Code, the report must be sent to the Office within 5 business days of receipt using a facility that offers next day delivery service. A material misstatement is defined as a collective amount of 10% or more of total assets, total liabilities, or total capital and surplus.

(4) Section 624.316(2)(e), F.S., allows the Office to conduct examinations of an insurer by contracting for the services of an independent Certified Public Accountant, an actuary, a reinsurance specialist, an investment specialist,

information technology specialist, or any combination of these individuals, as the particular circumstances of the examination require. An examination performed pursuant to this subsection must meet the requirements of subsection (1).

(a) through (i) No change

(j) All requests for reimbursement of travel expenses are to be made on Form DFS-C1-500 State of Florida Voucher For Reimbursement of Travel Expenses, (Rev.12/13 ~~07/08~~). This form is incorporated by reference and adopted by this rule for this purpose. It is available at http://www.floir.com/sitedocuments/DFS-C1-500.xls.

(k) Upon receipt and review of the contractor's request for payment, the Office will invoice the insurer being examined and the insurer shall make payment to the Office pursuant to Sections 624.316(2)(e)3. and 624.320(1) ~~(2),~~ F.S.

(l) Upon receipt of the payment from the insurer being examined, the Office will make payment to the contractor in accordance with the rates and terms set out in the contract. ~~completed Form OIR-A1-1976, Professional Services Agreement for Non-Employee Examination.~~

~~(m) Forms OIR-A1-1976, Professional Services Agreement for Non-Employee Examination (12-08); OIR-A1-1977, Scope of Services Addendum to Professional Services Agreement for Non-Employee Examination (12-08); and OIR-A1-1978, Amendment to Scope of Services Addendum (12-08), are incorporated by reference and adopted herein as the contracts by which the contractors are retained. All forms referenced in this rule are available for viewing at the Office's homepage at www.floir.com/iportal.~~

(5) No change

Rulemaking Authority 624.308(1), 624.316(2) FS. Law Implemented 624.307(1), 624.316, 624.3161, 624.320, 624.321(1), 624.424 FS. History–New 6-9-93, Amended 11-23-94, 4-4-99, Formerly 4-138.005, Amended 7-1-09 Amended_____.

69O-138.021 Special Consent Investments.

(1) No change

(2) Automatic Revocation and Renewal Procedure.

(a) through (b) No change

(c) All requests for special consent investments shall be clearly labeled as such~~, shall be submitted in writing,~~ and

shall contain the following information: name and NAIC code number of the insurer requesting the special consent; nature and amount of the proposed investment; requested dates of approval and expiration; reason for the special consent request; date of submission for approval; and information regarding any previous special consents granted to the insurer for the same or nearly the same investments. All filings shall be submitted electronically to http://www.floir.com/iportal.

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 625.331 FS. History–New 6-15-92, Formerly 4-138.02 Amended_____.

69O-138.041 Scope.

(1) No change

(2) This rule shall be applicable to all annual statements filed with the Office ~~after the effective date of this rule~~. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with Rule 69O-138.046, F.A.C., of this part, and a memorandum in support thereof in accordance with Rule 69O-138.047, F.A.C., of this part, shall be required each year. All filings shall be submitted electronically to http://www.floir.com/iportal.

Rulemaking Authority 624.308(1), 625.121(3)(a) FS. Law Implemented 624.307(1), 624.316(1)(c), 624.424(1), 625.121(3) FS. History–New 5-18-93, Amended 2-16-94, 1-23-03, Formerly 4-138.041 Amended_____.

69O-138.043 General Requirements.

(1) Submission of Statement of Actuarial Opinion.

(a) Included on or attached to Page 1 of the annual statement for each year, ~~beginning with the year in which this part becomes effective~~, shall be the statement of an appointed actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with Rule 69O-138.046, F.A.C.

(b) No Change

(2) Qualified Actuary.

(a) No change

(b) Any appointed actuary will be considered to be a "Qualified Actuary" if he or she:

1. through 5. No Change

(c) Once notice is furnished, no further notice is required with respect to this person provided the company shall give the Office written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in paragraph 69O-138.043(2)(b), F.A.C. Notice must be prior to or concurrent with the termination of the actuary's appointment or retention, or upon discovery that the actuary no longer meets the requirements set forth in paragraph 69O-138.043(2)(b), F.A.C. All filings shall be submitted electronically to http://www.floir.com/iportal.

(d) No change

(3) through (4) No change

Rulemaking Authority 624.308(1), 625.121(3)(a) FS. Law Implemented 624.307(1), 624.316(1)(c), 624.424(1), 625.121(3) FS. History–New 5-18-93, Amended 2-16-94, 1-23-03, Formerly 4-138.043 Amended_____.

69O-137.003 Premium Growth Reporting.

Section 624.4243(3), F.S., requires that a form for reporting premium growth be adopted by rule for each insurer that has been authorized to transact property and casualty insurance in Florida for less than three years. Form OIR-A1-1229 (rev 9/06 ~~7/01~~), entitled "Office of Insurance Regulation Premium Growth Reporting Form," is hereby incorporated by reference to be the form specified in Section 624.4243(3), F.S., for reporting premium growth. Forms are available at http://www.floir.com/iportal. ~~This form may be obtained from the Document Processing Section, Division of Administration, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0311. Forms are additionally available and may be printed from the office's web site: www.dfs.state.fl.us.~~ All forms may be reproduced at will.

Rulemaking Authority 624.4243(3) FS. Law Implemented 624.4243 FS. History–New 3-26-98, Amended 3-27-02, Formerly 4-137.003 Amended_____.

69O-137.009 Filing Procedures for Commercial and Personal Residential Property Supplemental Quarterly Report.

(1) The procedures in this rule apply to all commercial and residential property policies as defined below. Each insurer or insurer group doing business in Florida shall file with the office~~, beginning with the first quarter of 1996,~~ a supplemental report with information, listed by company, on personal lines and commercial lines residential property insurance policies written in this state. The data submitted shall be calculated from the end of the last business day of each month. Non-renewal information shall be determined by the policy expiration dates.

(2) through (3) No change

(4) The supplemental report shall be filed on a quarterly basis in conjunction with financial reports on Form OIR-D0-1185 (1/96) "Quarterly Supplemental Report", which is hereby adopted and incorporated by reference. The information shall ~~may~~ be submitted ~~either in hard copy form or on a computer diskette using a template developed by the Office in a specified software. This form or diskette may~~ or be obtained from the Office's website at http://www.floir.com/iportal. ~~Property & Casualty Solvency Section, Bureau of P & C Solvency, Market Conduct & Surplus Lines, Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, FL 32399-0329.~~

Rulemaking Authority 624.424(10) FS. Law Implemented 624.424(10) FS. History–New 7-3-96, Formerly 4-137.009 Amended_____.

69O-170.030 Loss Reserve Discounts.

(1) No insurer shall apply a discount to its loss reserves other than tabular workers' compensation loss reserves without special permission from the Office. An insurer shall request such special permission in writing, stating the line of insurance to be discounted and the rate of discount to be applied. Any insurer wishing to discount its December 31 reserves shall apply to the Office for special permission no later than December 1.

In evaluating the request to discount loss reserves, at a minimum, the Office shall consider the following:

a. The risk-based capital;

b. The ratio of loss and LAE reserves to surplus;

c. For insurers selling multi-year contracts, the ratio of the unearned premium reserve to surplus;

d. The ratio of ceded loss and loss adjustment expense reserves to surplus;

e. The quality of the reinsurance supporting the ceded loss adjustment expense reserves to surplus;

f. The one-year and two-year reserve development as a precentage of surplus over the last five years;

g. Gross and Net Writing Ratio to Surplus;

h. Whether the opining actuary of the insurer has been the opinion actuary of an insurance company that dropped to the company action level, mandatory control level, or receivership within five years of the date of the opinion.

All filings shall be submitted electronically to http://www.floir.com/iportal.

(2) through (6) No change

Rulemaking ~~Specific~~ Authority 624.308(1) FS. Law Implemented 624.307(1), 624.424, 625.091 FS. History–New 1-27-92, Formerly 4-170.030 Amended_____.

69O-142.015 Standardized Requirements Applicable to Insurers After Hurricanes or Natural Disasters.

This rule adopts standardized requirements that may be applied to insurers as a consequence of a hurricane or other natural disaster. The Office is authorized to issue an Order or Orders deemed necessary to protect the health, safety and welfare, activating the requirements herein, in whole or in part. An Order may be amended as deemed necessary to accommodate the particular circumstances of the specified hurricane or natural disaster. The following standardized provisions may be activated as provided herein:

(1) Claims Reporting Requirements

(a) No change

(b) The following form is hereby adopted and incorporated by reference:

1. OIR-DO-1681 (revised 05/2007) "Catastrophic Event Data Reporting and Analysis" and is

~~2. Copies of the form are~~ available ~~and may be printed~~ from the Office's website: http://www.floir.com/iportal.

2 ~~3~~. All information shall be submitted electronically through http://www.floir.com/iportal. ~~https://iportal.fldfs.com.~~

(2) Other property coverages where loss is not specifically excluded in the policy's outline of coverage such as:

(a) No change

(b) Reinsurance contracts are not subject to this rule, however, ceding insurers shall, within ten (10) days, notify the Office, ~~in writing~~, of the cancellation or nonrenewal of any reinsurance contract reinsuring property risks located in the State. All filings shall be submitted electronically to http://www.floir.com/iportal. ~~The notice should be directed to Property and Casualty Financial Oversight.~~

(c) through (r) No change

Rulemaking Authority 624.308, 627.7019 FS. Law Implemented 624.307(1), 624.424, 624.319, 627.7019 FS. History–New 6-12-07 Amended_____.

69O-144.007 Credit for Reinsurance from Certified Reinsurers.

(1) through (17) No change

(18) All filings shall be submitted electronically to http://www.floir.com/iportal. Forms are available at http://www.floir.com/iportal. ~~Forms adopted in this rule are available on the Office's web site located at http://www.floir.com.~~

Rulemaking Authority 624.308, 624.610(14) FS. Law Implemented 624.307(1), 624.424, 624.610 FS. History–New 10-29-08, Amended 7-28-15 Amended_____.

69O-141.003 Plan of Correction.

(1) through (3) No change

(4) Any reports submitted to the Office pursuant to any approved corrective plan shall be electronically filed at http://www.floir.com/iportal ~~addressed to the Bureau of Administrative Services within the Office of Insurance Regulation~~ unless otherwise indicated through a consent order. All other reports required by statute or rule shall be submitted in the manner required by such statute or rule, regardless of whether the insurer is in administrative supervision.

(5) Any notice, request, or other communication received by an insurer while in administrative supervision from any person acting for the Office, but not responsible for the administrative supervision, ~~employed by the Bureau of Administrative Services,~~ shall be reported to the person in the office responsible for the administrative supervision ~~Bureau of Administrative Services~~ by the insurer within five (5) days of receipt.

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 624.610, 624.80, 624.81, 625.012, 625.172, 625.302, 625.330, 625.332, 625.338 FS. History–New 1-30-91, Formerly 4-93.003, Amended 5-5-92, Formerly 4-141.003 Amended_____.

69O-137.008 Filing of Statistical and Quarterly Reports for Individually Rated Risks and Excess Rates.

(1) Purpose and Scope. The purpose of this rule is to provide procedures for filing statistical reports for individually rated risks pursuant to Section 627.062(3)(a), F.S., and for excess rates pursuant to Section 627.171, F.S., since they are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules which have been filed with the Office. Every insurer in this state which is authorized to transact any of the lines of insurance subject to Part II of Chapter 627, F.S., and which rates risks on an individual or excess basis shall be subject to this rule. Reports for individually rated risks and excess rates shall be received by the Office on a quarterly basis for each company. The information shall be reported within 45 days of the close of each quarter on Form OIR-B1-588, "Office of Insurance Regulation/Property & Casualty – Quarterly Report/Individually Rated Risks and Excess Rates," rev. 7/03 ~~8/94~~, which is hereby adopted and incorporated by reference. A quarterly report need not be filed if no individually rated risks or risks subject to excess rates have been written during the quarter for which the report would otherwise be due. However, if an insurer does not file Form OIR-B1-588 because of not having written such business for four consecutive quarters, then for the quarter after the fourth consecutive quarter for which no business was written, the insurer shall file Form OIR-B1-588 and check the box thereon indicating that the insurer has not been subject to filing for the past four consecutive quarters. The form may be obtained from http://www.floir.com/iportal ~~the Bureau of Property and Casualty Forms and Rates, Division of Insurer Services, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0330.~~ A separate report must be completed for each quarter. The reports are due 45 days after the close of each quarter.

~~(2) Reports for individually rated risks and excess rates shall be received by the Department on a quarterly basis for each company. The information shall be reported within 45 days of the close of each quarter on Form OIR-B1-588, "Florida Department of Insurance/Property & Casualty Quarterly Report/Individually Rated Risks and Excess Rates," rev. 8/94, which is hereby adopted and incorporated by reference. A quarterly report need not be filed if no individually rated risks or risks subject to excess rates have been written during the quarter for which the report would otherwise be due. However, if an insurer does not file Form OIR-B1-588 because of not having written such business for four consecutive quarters, then for the quarter after the fourth consecutive quarter for which no business was written, the unsurer shall file Form OIR-B1-588 and check the box thereon indicating that the insurer has not been subject to filing for the past four consecutive quarters. The form may be obtained from the Bureau of Property and Casualty Forms and Rates, Division of Insurer Services, Department of Insurance, Larson Building, Tallahassee, FL 32399-0330. A separate report must be completed for each quarter. The reports are due 45 days after the close of each quarter.~~

(2) ~~(3)~~ Submitting the Report. Forms may be submitted by mailing a completed electronic version via email to OIRB1588@floir.com or by mailing a copy to Property and Casualty Product Review Unit, Office of Insurance Regulation, 200 E.

Gaines St., Tallahassee, FL 32399-0330.

~~(a) The insurer shall affix the bar code labels to the upper right-hand corner of Form OIR-B1-588, and shall mail the report to the following address: Office of Insurance Regulation, Post Office Box 5320, Tallahassee, Florida 32314-5320.~~

~~(b) Questions concerning bar code labels shall be directed to the Office of Insurance Research and Data Analysis at (850)922-3149, ext. 2676. Orders for additional bar code labels shall be submitted in writing, shall state the company's most current FEIN number, and shall be accompanied by a payment in the amount of $30 per company, to the Office of Insurance Research and Data Analysis at the address in paragraph (3)(a), above.~~

~~(c) Original forms with bar codes may be copied for use with future filings. The insurer is encouraged to keep the original bar code form for future copying and to mail only the copies.~~

Rulemaking Authority 624.308(1), 627.331(1) FS. Law Implemented 624.307(1), 624.418, 624.4211, 624.424(6), 627.062, 627.171, 627.331 FS. History–New 6-9-93, Amended 9-19-94, Formerly 4-137.008 Amended_____.

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

(1) through (2) No change

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

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

(4) through (5) No change

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

69O-191.054 Rates.

(1) No change

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

(a) No change.

(b) Filings, as that term is defined in paragraph (2) (a), shall be submitted to the Office electronically through http://www.floir.com/iportal. ~~mailed to: Office of Insurance Regulation, Division of Insurer Services, Bureau of Life and Health Forms and Rates, Post Office Box 8040, Tallahassee, Florida 32301-8040 or submitted electronically to~~

~~https://iportal.fldfs.com. All filings sent to the Office by Federal Express or any other form of special delivery shall be delivered to: Office of Insurance Regulation, Division of Insurer Services, Bureau of Life and Health Forms and Rates, 1st Floor, Larson Building, 200 East Gaines Street, Tallahassee, FL 32399-0328.~~

(c) No change

(3) through (4) No change

(5) HMOs with fewer than 1,000 Florida subscribers, for all individual forms combined or for all group forms combined, may, at their option, file a streamlined annualized rate increase filing not exceeding medical trend as provided in subsection 69O-149.003 (6) ~~(7),~~ F.A.C. The filing shall be made in accordance with paragraph 69O-191.054(2)(a), F.A.C., with a certification that the filing includes all individual forms or all group forms in lieu of the actuarial memorandum required by Rule 69O-191.055, F.A.C.

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

(b) through (e) No Change

(7) No change

(8) (a) through (b) No Change

(c) The effect of changes to the underlying age/gender slope, reduction in the anticipated loss ratio for the form, and change in the durational slope for individual contract forms, results in subscriber impact greater than 50 percent of medical trend, as defined by subsection 69O-149.003 (6) ~~(7),~~ F.A.C., unless phased-in over a 3 year period. A shorter time period shall be considered on a case-by-case basis based on unique situations and justification by the HMO. The HMO, at its option, may request a new business rate schedule based on the full effect of the new assumptions with the phase-in only applicable to existing subscribers.

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

69O-191.075 Annual and Quarterly Reports.

(1) Each HMO shall furnish to the Office an annual report at the time specified in Section 641.26, F.S., on a form

furnished by the Office of Insurance Regulation, Life and Health Financial Oversight ~~Bureau of Specialty Insurers, Tallahassee, Florida 32399-0300~~, incorporated in Rule 69O-191.107, F.A.C. ~~The financial statement shall also be filed on a diskette; the Office must approve the electronic format for reporting the financial information.~~ The annual report shall be submitted to the Office electronically through http://www.floir.com/iportal. The completed annual statement form shall be accompanied by the items required in Section 641.26, F.S., as well as a supplemental actuarial certification and an organization chart of the HMO identifying ownership and affiliated companies, and shall be submitted by April 1 or within three months after the end of its reporting period. The audit report required by Section 641.26, F.S., that is found to have assets which are not allowed pursuant to Section 641.35, F.S., shall be granted a fifteen (15) day extension from the date of notification of disallowed assets to resubmit a corrected audit report. The extension will be granted only for submission of a corrected audit report. If the Office determines that the HMO has been notified previously that the asset has been disallowed, the audit report will be deemed not filed. No extension shall be granted for correction of the audit report.

(2) through (5) No change

(6) Quarterly reports shall be submitted to the Office within forty-five (45) days following the end of each operating quarter. The initial operating quarter commences after the issuance of a Certificate of Authority. Quarterly reports shall be submitted on a form, provided by the Office of Insurance Regulation,Life and Health Financial Oversight ~~Bureau of Specialty Insurers, Tallahassee, Florida 32399-0300~~, incorporated ~~herein~~ by reference in rule 69O-137.001(3) and also be filed electronically ~~on a diskette~~ in accordance with subsection (1) of this section, and shall contain the following supplemental schedules:

(a) through (i) No change

(7) No change.

Rulemaking ~~Specific~~ Authority 641.36 FS. Law Implemented 624.424, 641.26(1) FS. History–New 2-22-88, Amended 10-25-89, Formerly 4-31.075, Amended 5-28-92, Formerly 4-191.075, Amended _____.

69O-191.107 Prescribed Forms.

(1) The forms listed below are incorporated into, and made a part of, these rules by reference.

DATE OF

FORM NUMBER	DESCRIPTION	LATEST REVISION
(a) OIR-C1-942~~HMO COA~~ Application ~~Form~~ For Certificate of Authority http://www.flrules.org/Gateway/reference.asp?No=Ref-08307	~~HMO COA~~ Application ~~Form~~ For Certificate of Authority Health Maintenance Organization	12/05 ~~2/92~~
~~(b) OIR-943~~	~~Quarterly Report of Subscriber Grievances (Summary)~~	~~11/91~~
~~(c) OIR-944~~	~~Individual Quarterly Grievance Report~~	~~11/91~~
~~(d) OIR-945~~	~~Request for Review by the Statewide Subscriber Assistance Panel~~	~~11/91~~
~~(e) OIR-946~~	~~HMO Response Form for Statewide Subscriber Assistance Panel~~	~~11/91~~
~~(f) OIR-947~~	~~Annual HMO Report Form~~	~~11/91~~
~~(g) OIR-948~~	~~Annual Report Supplement – Audited Financial Statement~~	~~11/91~~
(b ~~h~~) OIR-A2-949	Annual Report Supplement – Contracts Issued & Outstanding	07/04 ~~11/91~~
(c ~~i~~) OIR-A2-950	Annual Report Supplement – Damage Claims & Medical Injury	07/04 ~~11/91~~
~~(j) OIR-951~~	~~Annual Report Supplement – Actuarial Certification~~	~~11/91~~
~~(k) OIR-952~~	~~Annual Report Supplement – Actuarial Report~~	~~11/91~~
~~(l) OIR-953~~	~~Quarterly HMO Report Form~~	~~11/91~~
(d ~~m~~) OIR-C1-448	Acquisition Application	12/05 ~~5/89~~
(e ~~n~~) OIR-C1-938 http://www.flrules.org/Gateway/reference.asp?No=Ref-08296 ~~954~~	Fingerprint Payment and Submission Procedure ~~Card Instructions~~	5/13 ~~4/91~~
(f ~~o~~) OIR-C1-903	Fingerprint Invoice	12/05 ~~9/91~~
(g ~~p~~) OIR-C1-144	~~Consent and Agreement in Re:~~ Service of Process Consent and Agrement	06/04 ~~11/90~~
~~(q) OIR-414~~	~~Registration of Non-Office Representative~~	~~6/89~~

(hr)OIR-C1-1423 422	BiographicalAffidavit ~~Statement~~	8/14 ~~11/90~~
~~(s) OIR-449~~	~~Abbreviated Biographical~~	~~1/91~~
(i-t) OIR-C1-450	Authority for Release of Information	5/00 ~~8/91~~
(j) OIR-D0-516	Insurance Holding Company System Annual Registration Statement	5/16
(k) OIR-A2-1083	Annual Report Filing Fees	01/03
http://www.flrules.org/Gateway/reference.asp?No=Ref-08295		

(2) Form OIR-B2-1507, Form OIR-B2-1507A, and Form OIR-B2-1356 as incorporated in Rule 69O-149.022, F.A.C., are also used for purposed of this rule chapter.

(3) Copies of all forms listed in subsection (1) above may be obtained from ~~through~~ the Office of Insurance Regulation's web site: http://www.floir.com/iportal. ~~Bureau of Specialty Insurers, Tallahassee, Florida 32399-0300.~~

Rulemaking ~~Specific~~ Authority 624.308(1), 641.36 FS. Law Implemented 624.424, 627.410(6), (7), 627.413(4), 627.4145, 627.6699(12)~~(d)~~4., 627.6735, 627.682, 627.9407(2), 628.4615, 641.19(13)(d), 641.21(1), 641.26(1), (2), 641.29 FS. History–New 2-22-88, Amended 10-25-89, Formerly 4-31.107, Amended 5-28-92, 8-15-94, 8-15-02, Formerly 4-191.107Amended_____.

69O-196.005 Filing Surety Bond in Lieu of Net Worth.

(1) A surety bond in the amount of $35,000.00 may be filed with the Office ~~department~~ by premium finance companies in conjunction with a $10,000 minimum net worth; and all filings shall be submitted electronically to http://www.floir.com/iportal.

(2) through (3) No change

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.424, 627.828 FS. History–New 10-20-73, Repromulgated 12-24-74, Formerly 4-18.05, 4-18.005, Amended 8-29-99, Formerly 4-196.005 Amended_____.

69O-196.007 Annual Reports.

(1) No change

(2) The annual report shall be filed on form OIR-A3-107(11/97), Annual Report, which is incorporated by reference in Rule 69O-196.015, F.A.C. Each page of the form shall be completed and prepared according to the instructions. An incomplete form shall be returned and considered not filed by the Office. Failure to file a complete annual report by the due date shall subject a licensee to fines as set forth in Rule 69O-207.001 ~~7~~, F.A.C., and discipline as provided in Sections 627.832 and 627.833, F.S. All filings shall be submitted electronically to http://www.floir.com/iportal.

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.424, 627.836 FS. History–New 10-20-73, Repromulgated 12-24-74, Formerly 4-18.07, 4-18.007, Amended 7-27-95, 8-29-99, Formerly 4-196.007 Amended_____.

69O-196.009 Other Reports and Corrective Action Plans.

To aid the Office in determining a licensee's continued eligibility to hold a premium finance license:

(1) No change

(2) Changes in senior corporate officers, chief executive officer, chief financial officer, or directors (or members of a properly authorized and appointed executive committee thereof), or if the licensee is not incorporated, changes in management personnel who have decision or policy-making authority over the premium finance company, shall be reported in writing to the Office within 60 days after the effective date of the change. Such changes will require completion of biographical information in the form required by the Office adopted in Rule 69O-196.015 and an

independent investigative background report of the person or entity, plus an investigation fee. All filings shall be submitted electronically to http://www.floir.com/iportal.

(3)through (6) No change

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 624.80, 624.81, 627.828, 627.829, 627.832, 627.834, 627.836, 627.849, 628.4615 FS. History–New 7-27-95, Formerly 4-196.009 Amended_____.

69O-196.015 Forms Incorporated by Reference.

The following forms are incorporated into this rule chapter by reference to implement the provisions of Chapter 627, Part XV, F.S.:

Title	Form Number
~~(1) Application for License to Conduct Business in the State of Florida as a Premium Finance Company~~	~~OIR-99 (10/94)~~
~~(a) Application for Certificate of Authority Premium Finance Company~~	~~OIR-979 (10/94)~~
(1)(a) ~~(b) Instructions for Application~~ Application For License Premium Finance Company	OIR-C1-958 (5/2013)~~(6/95)~~
~~(c) Checklist for Application~~	~~OIR-972 (6/95)~~
~~(d) Request for Payment of Application Fees~~	~~OIR-971 (10/94)~~
(b) ~~(e)~~ Management Information Form	OIR-844 (10/91)
(c) ~~(f)~~ Listing of Stockholders	OIR-973 (10/91)
(d) ~~(g)~~ Instructions for Statutory Compliance of Forms	OIR-957 (6/95)
(2) Annual Report	OIR-A1-107 (11/97)
(3) Bond	OIR-453 (6/95)
(4) Authority to Release Information	OIR-450 (6/95)
(5) Biographical Statement and Affidavit	OIR-422 (11/90)
(6) Personal Financial Statement	OIR-454 (5/89)
(7) Fingerprint Card Instructions	OIR-938 (4/91)
(8) Request for Payment of Fingerprint Charges	OIR-903 (1/94)

(9) Instructions for Furnishing Background Investigation Reports	OIR-905 (9/94)
(10) Application for Acquisition of a Premium Finance Company	OIR-448 (12/91)
(a) Consent and Agreement in Re Service of Process	OIR-144 (11/90)
(b) Resolution Form	OIR-514 (11/90)
~~(11) Statement of Account~~	~~OIR-970 (10/91)~~

~~These forms shall become effective on the date this rule becomes effective.~~ Forms are available at http://www.floir.com/iportal.~~Copies of the forms may be obtained from the Office of Insurance Regulation, Bureau of Specialty Insurers, Larson Building, Tallahassee, FL 32399-0331.~~

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.321(1)(a), 624.424, 627.828, 627.829, 627.836, 627.845, 628.4615 FS. History–New 5-28-90, Formerly 4-18.015, Amended 7-27-95, 8-29-99, Formerly 4-196.015 Amended_____.

69O-196.021 Disclosure Requirements for Insurance Coverages Financed With Personal Injury Protection.

(1) No change

(2) The disclosure shall be on Form OIR-A3-1162 (3/95), "Insurance Premium Financiag Disclosure Form which is incorporated herein by reference. Forms are available at http://floir.com/iportal. All filings shall be submitted electronically to http://www.floir.com/iportal. ~~A blank form can be obtained from the Bureau of Specialty Insurers, 200 East Gaines Street, Tallahassee, Florida 32399-0331, from which you may make as many copies as needed. Photocopies of Form OIR-1162 (3/95) are acceptable, provided that the copies are clearly legible and contain no alterations in text and type size.~~

(3) through (4) No change

Rulemaking ~~Specific~~ Authority 627.8405 FS. Law Implemented 624.424, 626.9541(1)(a), 627.734, 627.8405 FS. History–New 3-1-95, Amended 8-16-95, Formerly 4-196.021 Amended_____.

69O-196.025 Statement of Account; Receipts.

(1) The Office has adopted a standard form which is acceptable for the use of premium finance companies in

meeting the requirements of this part. Upon request of the premium finance company, the Office will provide form OIR-A3-970 (11/91), which is incorporated herein by reference ~~in Rule 69O-196.015, F.A.C.~~, from which the company may make as many copies as necessary. Forms are available at http://www.floir.com/iportal. All filings shall be submitted electronically to http://www.floir.com/iportal.

(2) In the alternative, a premium finance company may submit its own form to the Office for approval, ~~together with the appropriate form filing fee,~~ which form must contain the same minimun, in any logical configuration.

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 627.845, 626.9541(1)(a) FS. History–New 7-27-95, Formerly 4-196.025 Amended _____.

69O-196.035 Required Books and Records.

At a minimum for permanent books and records, each licensed premium finance company shall maintain:

(1) through (8) No change

(9) Copies of all contracts with independent contractors or third parties performing services directly or indirectly related to the premium finance business. Each such contract shall be submitted to the Office and shall contain at a minimum the following provisions: All filings shall be submitted electronically to http://www.floir.com/iportal.

(a) through (d) No change

(10) No change

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 627.828, 627.834, 627.836, 627.838, 627.840, 627.8405, 627.841, 627.844, 627.845, 627.848, 627.849 FS. History–New 7-27-95, Formerly 4-196.035 Amended _____.

69O-199.008 General Eligibility Requirements.

(1) Biographical statements (Form OIR-422 as adopted in Rule 69O-199.015, F.A.C., on the following persons shall be included in the application for a Certificate of Authority (COA):

(a) Persons who own or control in excess of five percent of the outstanding stock of the home warranty association;

(b) Members of the board of directors of the home warranty association;

(c) All officers who are identified in Section 634.306, Florida Statutes, and any other individuals who have policy decision making authority;

(d) All officers and directors of any parent corporation or corporations of the home warranty association, if parent exists; and,

(e) All officers and directors of any external management company contracted with the home warranty association, if management company exists, pursuant to paragraph (1) (c) above.

(2) This requirement also applies to individuals who, subsequent to the date of application for a COA, become associated with a home warranty association and meet any of the qualifications listed in (1) (a) through (1) (e) above.

(3) Home warranty associations are required to notify the Office in writing within 15 days of any new officers, directors, or stockholders owning 5% or more of the outstanding voting securities of the home warranty association.

(4) Home warranty associations are required to notify the Office in writing within 15 days of any change in the corporate name, business name, trademark, or emblem of the association.

(5) All filings shall be submitted electronically to http://www.floir.com/iportal.

Rulemaking ~~Specific~~ Authority 634.302 FS. Law Implemented 624.424, 634.304, 634.306, 634.3073, ~~634.313~~ FS. History–New 7-16-92, Amended 4-3-94, Formerly 4-199.008 Amended_____.

69O-199.010 License Renewal.

(1)(a) through (b) No change

(c) The renewal form and a fee of $200.00 shall be received by the Office annually at least 30 days prior to June 1 of each year. All filings shall be submitted electronically to http://www.floir.com/iportal.

(d) No change

(2) No change

Rulemaking ~~Specific~~ Authority 634.302 FS. Law Implemented 624.424, 634.307 FS. History–New 7-16-92, Amended

4-3-94, Formerly 4-199.010 Amended_____.

69O-199.012 Annual Statement ~~and Quarterly Reports.~~

(1)(a) An Annual Report ~~annual statement~~ shall be filed with the Office of Insurance Regulation~~, Bureau of Specialty Insurers,~~ on or before March 1 of each year on the form prescribed by the Office in rule 69O-199.015..

(b) No change

(2) No change

~~(3) (a) Quarterly reports shall be filed with the Office of Insurance Regulation, Bureau of Specialty Insurers, on the form prescribed by the Department.~~

~~(b) If the quarterly report does not include substantially all information requested in the format provided, it will not be deemed filed until all deficiencies are corrected.~~

~~(c) Failure to timely file the quarterly reports may result in administrative action to suspend or revoke the license.~~

~~(4) The Quarterly Reports are due as follows:~~

~~Period~~	~~Due~~
~~First Quarter (March 31)~~	~~May 15~~
~~Second Quarter (June 30)~~	~~August 15~~
~~Third Quarter (September 30)~~	~~November 15~~

(3) ~~(5)~~(a) Any request for an extension of filing the annual report shall be in writing and the reason(s) for the extension explained in detail.

(b) through (c) No change

(4) All filings shall be submitted electronically at http://www.floir.com/iportal.

Rulemaking ~~Specific~~ Authority 634.302, ~~634.308(1)(a)~~ FS. Law Implemented 624.307(1), 624.424, 634.313 FS. History–New 7-16-92, Amended 4-3-94, Formerly 4-199.012 Amended_____.

69O-199.015 Forms Incorporated by Reference.

(1) The following forms are incorporated into this rule chapter by reference to implement the provisions of Chapter 634, Part II, Florida Statutes:

Title	Form Number

(a) Application for License Home Warranty Association ~~License~~	OIR- C1-490 http://www.flrules.org/Gateway/reference.asp?No=Ref-08297 12/05 ~~(02/90)~~
(b) Annual Report	OIR-A3- 491 http://www.flrules.org/Gateway/reference.asp?No=Ref-08300 (03/91)
~~(c) Quarterly Report~~	~~OIR-492 (03/91)~~
(c)(~~d~~) Statement of Acquisition, Merger or Consolidation of A Specialty Insurer Pursuant to Florida Statutes 628.461, 628.4615	OIR-C1-448 (12/05) ~~(05/89)~~
(d) (~~e~~) Consent and Agreement in re Service of Process	OIR- C1-144 (11/90)
(e) (~~f~~) Authority to Release Information	OIR- C1-450 (08/91)
(f) (~~g~~) Biographical Statement and Affidavit	OIR-422 (11/90)
(g) (~~h~~) Abbreviated Biographical Statement	OIR-449 (01/91)
(h) (~~i~~) Home Warranty Bond	OIR-455 (01/89)
(i) (~~j~~) Certification of Filing Annual Tax on Premiums and Assessment	OIR-440 (12/89)
(j) (~~k~~) Resolution Form	OIR-514 (11/90)
(k)(~~l~~) Renewal Notice	OIR-1073 (04/92)

(2) Forms are available at http://www.floir.com/iportal. ~~These forms are effective on the dates referenced above. Copies of the forms may be obtained from the Office of Insurance Regulation, Bureau of Specialty Insurers, Larson Building, Tallahassee, FL 32399-0300.~~

Rulemaking ~~Specific~~ Authority 634.302 FS. Law Implemented 624.424, 634.306, 634.3073, 634.3077, 634.313, 634.315 FS. History–New 7-15-90, Formerly 4-118.015, Amended 7-16-92, Formerly 4-199.015 Amended _____.

69O-198.010 License Continuance.

(1)(a) No change

(b) Form OIR-A3-110 and a fee of $200.00 should be received by the Office annually in conjunction with the March 1 filing of the annual statement.

(c) A manufacturer or affiliate should use Form OIR-A3-955, which should be received by the Office annually in conjunction with the March 1 filing of the annual statement, together with a fee of $500.00.

(2) No change

(3) Forms are available at http://www.floir.com/iportal. All filings shall be submitted electronically to http://www.floir.com/iportal.

Rulemaking ~~Specific~~ Authority 634.402 FS. Law Implemented 624.424, 634.408 FS. History–New 12-26-88, Formerly 4-67.010, Amended 3-28-93, Formerly 4-198.010 Amended_____.

69O-198.012 Annual Statement ~~and Quarterly Reports.~~

(1) An Annual Statement is required to be filed with the Office of Insurance Regulation~~, Bureau of Specialty Insurers,~~ on or before March 1 of each year on Form OIR-A3-456 (05/90) as incorporated by reference in subsection 69O-198.015(1), F.A.C. If the statement is not complete to include all information requested in the format provided, it will not be deemed filed until all deficiencies are corrected.

~~(2) Quarterly Reports are required to be filed with the Office of Insurance Regulation, Bureau of Allied Lines, on the form prescribed by the Office. If Quarterly Reports are not complete to include all information requested in the format provided, it will not be deemed filed until all deficiencies are corrected. Failure to file the Quarterly Reports in a timely manner may result in administrative action to suspend or revoke the license.~~

~~(3) The Quarterly Reports are due as follows:~~

~~PERIOD~~	~~DUE~~
~~First Quarter (March 31)~~	~~May 15~~
~~Second Quarter (June 30)~~	~~August 15~~
~~Third Quarter (September 30)~~	~~November 15~~

(2) Forms are available at http://www.floir.com/iportal. All filings shall be submitted electronically to http://www.floir.com/iportal.

Rulemaking ~~Specific~~ Authority 634.402 FS. Law Implemented 624.424, 634.415 FS. History–New 12-26-88, Amended 4-26-90, Formerly 4-67.012, 4-198.012 Amended _____.

69O-188.022 Filing of the Commercial Self-Insurance Fund Experience Reporting Form.

(1) No change

(2) Each fund shall, upon filing its initial Form OIR-EX and Form OIR-IA, elect to report on either a policy year or calendar-accident year basis. Thereafter, the reporting shall be on a consistent basis from year to year. Any changes in accounting or actuarial technique used in developing data shall be approved by the Office ~~Department~~. All filings shall be submitted electronically to http://www.floir.com/iportal.

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 624.470, 624.474, 624.488 FS. History–New 12-17-90, Formerly 4-78.022, 4-188.022 Amended _____.

69O-188.023 Filing of the Annual Statement by Commercial Self-Insurance Funds.

(1) Each commercial self-insurance fund shall submit electronically to http://www.floir.com/iportal. ~~comply with Rule Chapter 69O-137, F.A.C., Insurer Annual Statement Diskette Filing Specifications.~~ For the purpose of complying with Rule Chapter 69O-137, F.A.C., a commercial self-insurance fund shall be considered an authorized insurer, except that the fund's annual statement shall be due on or before April 1 of each year.

(2) through (3) No change

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 624.470, 624.474, 624.488 FS. History–New 12-17-90, Formerly 4-78.023, 4-188.023 Amended _____.

69O-188.024 Deficiency/Assessment Procedure.

(1) through (3) No change

(4) The fund may petition the Office within thirty (30) days of filing Forms OIR-EX and OIR-IA, to delay levying an assessment if it believes to do so is prudent. The Office shall grant the petition if the fund demonstrates to the satisfaction of the Office that the deficiency indicated on Form OIR-EX is likely to be resolved without an assessment. While such petition is under consideration by the Office, the sixty (60) day requirement in subsection 69O-188.024(1), F.A.C., shall not be applicable. However, if such petition is denied by the Office, the fund shall levy the assessment within sixty (60) days of such denial. All forms shall be submitted electronically to http://www.floir.com/iportal.

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 624.470, 624.474, 624.488 FS. History–New 12-17-90, Formerly 4-78.024, 4-188.024 Amended _____.

69O-143.013 Exemption from Section 625.76 of the Act of Acquisitions of Shares of Stock and Stock Options under Certain Stock Bonus, Stock Option or Similar Plans.

Any acquisition of shares of stock (other than stock acquired upon the exercise of an option, warrant or right) pursuant to a stock bonus, profit sharing, retirement, incentive, thrift, savings or similar plan, or any acquisition of a qualified or a restricted stock option pursuant to a qualified or a restricted stock option plan, or a stock option pursuant to an employee stock purchase plan, by a director or officer of an insurer issuing such stock or stock option shall be exempt from the operation of Section 625.76, F.S., of the Act, if the plan meets the following conditions:

(1) The plan has been approved directly or indirectly;

(a) No change

(b) By the written consent of the holders of a majority of the securities of such insurer entitled to vote: provided, however, that if such vote or written consent was not solicited substantially in accordance with the proxy rules and regulations prescribed by the Office ~~Director~~ in effect at the time of such vote or written consent, the insurer shall furnish in writing to the holders of record of the securities entitled to vote for the plan substantially the same information concerning the plan which would be required by any such rules and regulations so prescribed and in effect at the time such information is furnished, if proxies to be voted with respect to the approval or disapproval of the plan were then being solicited, on or prior to the date of the first annual meeting of security holders held subsequent to the later of;

1. The date the Act first applies to such insurer; or

2. The acquisition of an equity security for which exemption is claimed.

Such written information may be furnished by mail to the last known address of the security holders of record within 30 days prior to the date of mailing. Four copies of such written information shall be filed with~~, or mailed for filing to~~, the Office ~~Director~~ electronically at http://www.floir.com/iportal not later than the date on which it is first sent or given to security holders of the insurer. For the purposes of this paragraph, the term "insurer" includes a predecessor corporation if the plan or obligations to participate thereunder were assumed by the insurer in connection with the succession.

(2) through (4) No change

Rulemaking Authority 625.82 FS. Law Implemented 624.424, 625.76 FS. History–New 4-23-66, Amended 1-22-68, Repromulgated 12-24-74, Formerly 4-19.13, 4-19.013, 4-143.013 Amended_____.

69O-143.030 Information to Be Furnished to Stockholders.

(1) through (2) No change

(3) Two copies of each report sent to the stockholders pursuant to this section shall be filed electronically with the Office at http://www.floir.com/iportal ~~mailed to the Director~~ not later than the date on which such report is first sent or given to stockholders or the date on which preliminary copies of solicitation material are filed with the Office ~~Director~~, pursuant to subsection (1) of Rule 69O-143.032, F.A.C., of this rule, whichever date is later.

(4) No change

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 628.152 FS. History–New 3-18-65, Amended 1-22-68, Repromulgated 12-24-74, Formerly 4-17.05, 4-17.005, 4-143.030 Amended_____.

69O-143.032 Material Required to Be Filed.

(1) through (5) No change

(6) Notwithstanding the provisions of subsections (1) and (2) hereof and of subsection (5) of Rule 69O-143.035, F.A.C., copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the Office ~~Director~~ prior to use or publication. Definitive copies, however, shall be filed with ~~or mailed for filing to~~ the Office ~~Director~~ as requested by subsection (3) hereof not later than the date such material is used or published. The provisions of subsections (1) and (2) hereof and subsection (5) of Rule 69O-143.035, F.A.C., shall apply, however, to any reprints or reproductions of all or any part of such material. All filings made pursuant to this rule shall be submitted electronically at http://www.floir.com/iportal.

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 628.152 FS. History–New 3-18-65, Repromulgated 12-24-74, Formerly 4-17.07, 4-17.00, 4-143.032 Amended_____.

69O-143.035 Special Provisions Applicable to Election Contests.

(1) through (5) No change

(6) Application of this section to Report. Notwithstanding the provisions of subsections (1) and (2) of Rule 69O-143.030, F.A.C., two copies of any portion of the report referred to in subsection (1) of Rule 69O-143.030, F.A.C., which comments upon or refers to any solicitation subject to this section, or to any participant in any such solicitation, other than the solicitation by the management, shall be filed with the Office ~~Director~~ as proxy material subject to this

rule. Such portion of the report shall be filed with the Office ~~Director~~, in preliminary form, at least five business days prior to the date copies of the report are first sent or given to the stockholders. All filings required by this rule shall be filed electronically at http://www.floir.com/iportal.

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.424, 628.152 FS. History–New 3-18-65, Repromulgated 12-24-74, Formerly 4-17.10, 4-17.010, 4-143.035 Amended_____.

69O-143.042 Custody Agreement; Requirements.

(1) No Change

(2) No Change

(a) through (h) No change

(i) The custodian shall provide, upon written request from the Office or from an appropriate officer of the insurance company, the appropriate affidavits, on Forms OIR-A1-341 (A), (B), or (C) (rev. 12-07), or substantially similar forms with respect to custodied securities. Forms OIR-A1-341 (A), (B) and (C) (rev. 12-07), entitled "Custodian Affidavit," are hereby incorporated by reference. ~~These forms shall become effective on the effective date of these rules, and may be obtained from the Office of Insurance Regulation, Larson Building, Tallahassee, Florida~~. Forms are available at http://www.floir.com/iportal.

(j) through (n) No change

(o) The custodian shall provide written notification to the Office if the custodial agreement with the insurer has been terminated or if 100% of the account assets in any one custody account have been withdrawn. This notification shall be remitted to the Office within three (3) business days of the receipt by the custodian of the insurer's written notice of termination or within three (3) business days of the withdrawal of 100% of the account assets. All filings shall be submitted electronically to http://www.floir.com/iportal.

(3)(a) Nothing in this rule shall prevent an insurance company from depositing securities with another insurance company with which the depositing insurance company is affiliated, provided that the securities are deposited pursuant to a written agreement authorized by the board of directors of the depositing insurance company or an authorized committee thereof and that the receiving insurance company is organized under the laws of one of the states of the United States of America or of the District of Columbia. If the respective states of domicile of the depositing and receiving insurance companies are not the same, the depositing insurance company shall have given notice of the

deposit to the insurance commissioner in the state of its domicile and the insurance commissioner shall not have objected to it within thirty (30) days of the receipt of the notice. All filings shall be submitted electronically to http://www.floir.com/iportal.

(b) No change

Rulemaking Authority 624.308(1), 628.511(1), (4), 628.535 FS. Law Implemented 624.307(1), 624.424, 625.55, 628.511 FS. History–New 2-7-85, Formerly 4-66.02, 4-66.002, 4-143.042, Amended 5-13-08 Amended_____.

69O-143.046 Registration of Insurers.

(1) No change

(2) All filings required by this rule shall be submitted electronically to the Office via the Regulatory Electronic Filing System, "REFS." at http://www/floir.com/iportal.

(3) Every insurer subject to registration shall file a registration statement on a Form OIR-D0-516, "Form B – Insurance Company Holding System Registration Statement," rev. 5/16, http://www.flrules.org/Gateway/reference.asp?No=Ref-06549. ~~Insurers may obtain the form from the Office's website, located at http://www.floir.com.~~ The form shall provide current information about:

(a) through (g) No change

(4) through (15) No change

Rulemaking Authority 624.308, 628.801 FS. Law Implemented 624.307(1), 624.317, 624.424, 628.251, 628.461, 628.801 FS. History–New 12-16-70, Formerly 4-26.02, Amended 6-7-90, 1-30-91, Formerly 4-26.002, 4-143.046, Amended 5-31-16, Amended_____.

69O-143.047 Standards.

(1) through (3) No change

(4) The following transactions involving a domestic insurer and any person in its holding company system may not be entered into unless the insurer has notified the Office, via Form OIR-A1-2117, "Form D – Prior Notice of a Transaction," new 5/16, http://www.flrules.org/Gateway/reference.asp?No=Ref-06551, which is hereby adopted and incorporated by reference, and is available at www.floir.com/iportal, of its intention to enter into such a transaction at least thirty (30) calendar days prior thereto, or such shorter period as the Office in its discretion may permit, and the

Office has not disapproved it within such period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the insurer.

(a) through (e) No change

(5) through (9) No change

(10) All filings shall be submitted electronically to http://www.floir.com/iportal.

Rulemaking Authority 624.308, 628.801 FS. Law Implemented 624.317, 624.424, 628.251, 628.371, 628.381, 628.461, 628.801, 628.803, 624.307(1) FS. History–New 12-16-70, Formerly 4-26.03, Amended 1-30-91, Formerly 4-26.003, 4-143.047, Amended 5-31-16 Amended_____.

69O-201.010 License Continuance.

(1)(a) No change

(b) The qualified license holder shall file for continuance of its license on form OIR-A3-1077 adopted in Rule 69O-201.015, F.A.C. Forms are available at http://www.floir.com/iportal. All filings shall be submitted electronically to http://www.floir.com/iportal.

(c) The renewal notice and application form and a fee of $300.00 ~~$200.00~~ must be received by the Office prior to June 1 of each year.

(d) No change

(2) No change

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.416, 642.0301, 624.424, 642.032 FS. History–New 6-23-92, Formerly 4-201.010 Amended_____.

69O-201.012 Annual Statement and Quarterly Reports.

(1)(a) An annual statement and a $100 ~~$60~~ filing fee shall be filed with the Office of Insurance Regulation~~, Bureau of Specialty Insurers,~~ on or before March 1 of each year on form OIR-A3-479 adopted in Rule 69O-201.015, F.A.C.

(b) No change

(2) No change

(3)(a) Quarterly reports shall be filed with the Office of Insurance Regulation~~, Bureau of Specialty Insurers,~~ on form OIR-A3-481 as adopted in Rule 69O-201.015, F.A.C.

(b) through (c) No change

(4) through (5) No change

(6) All filings shall be submitted electronically to http://www.floir.com/iportal.

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 624.416, 624.424, 642.0301, 642.032 FS. History–New 6-23-92, Formerly 4-201.012 Amended_____.

69O-170.007 Annual Rate Filings.

(1)(a) through (c) No change

(d) For purposes of identifying filings submitted to the Office, a line of business shall be identified by one of the following, although additional identification may be used as needed:

~~1. Commercial Automobile;~~

1~~2~~. Commercial Multiple Peril Policy (with indivisible premium);

2~~3~~. Dwelling Fire and Liability;

3~~4~~. Homeowners;

4~~5~~. Mobile Homeowners;

5~~6~~. Motor Home and Motorcycle;

6~~7~~. Personal Inland Marine;

7~~8~~. Personal Liability; and

8~~9~~. Private Passenger Automobile.

(2) through (5) No change

Rulemaking ~~*Specific*~~ *Authority 624.308, 624.424(1)(c) FS. Law Implemented 624.307, 624.418(2), 624.4211, 624.424(1)(c), 627.021, 627.062, 627.0645, 627.0651, 627.221, 627.301 FS. History–New 12-25-90, Formerly 4-72.007, Amended 1-27-92, 3-9-93, 9-7-93, 12-17-00, Formerly 4-170.009, Amended 9-5-07 Amended_____.*

69O-175.021 Insurer Experience Reporting - Excessive Profits, Automobile Insurance.

(1) Any insurer authorized to transact private passenger automobile insurance in the state shall report the information required by Sections 627.931(1) and 627.066, F.S., or required by rule, by completing and submitting to the Office of Insurance Regulation form OIR-B1-307 "Private Passenger Automobile Excessive Profits Reporting Form" in accordance with the instructions provided therein which is adopted and incorporated herein by reference.

(2) through (3) No change

(4) Form OIR-B1-307(7/03), http://www.flrules.org/Gateway/reference.asp?No=Ref-08273 is available at and shall be submitted electronically through the Data Collection and Analysis Module (DCAM) at http://www.floir.com/iportal.~~as amended, shall take effect on the amended date of this rule.~~

Rulemaking ~~Specific~~ Authority 624.308(1) FS. Law Implemented 624.307(1), 624.424, 627.066, 627.915(1) FS. History–New 1-16-83, Amended 6-14-84, Formerly 4-59.06, 4-59.006, Amended 1-27-92, Formerly 4-175.021 Amended_____.

69O-167.011 Homeowner's Policies: Offer of Replacement Cost Coverage and Law and Ordinance Coverage.

(1) through (2) No change

(3) Insurers shall obtain ~~the required written statement in one of two ways. The insurer may use Form OIR-1148, "Rejection or Selection of Important Additional Coverages," rev. 4/94, which is hereby adopted and incorporated by reference. Insurers using Form OIR-1148 must use that same form to provide the required notice of availability every three years. Copies of the form may be obtained from the Bureau of Property and Casualty Forms and Rates, Division of Insurer Services, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0330. The form may be reproduced at will. Alternatively, the insurer may use its own form if the form is approved by the Office. A request for approval shall be submitted to the Bureau of Property and Casualty Forms and Rates and the Office will approve the form if it contains substantially the same explanation and check-off opportunities as Form OIR-1148. If an insurer receives~~ approval to use its own form,and ~~the insurer~~ must use an approved ~~that same~~ form for the required notification every three years. Such ~~Whichever~~ form ~~is~~ used by the insurer shall be retained by the insurer in the policyholder's file.

(4) No change

Rulemaking Authority 624.308(1) FS. Law Implemented 624.307(1), 624.424, 627.7011 FS. History–New 11-2-94, Formerly 4-167.011 Amended_____.

69O-194.030 Forms Incorporated by Reference.

The following forms are incorporated into this rule chapter by reference to implement the provisions of Chapter 641, Part III, Florida Statutes:

	Title	Form Number
(1)	Application for Certificate of Authority Prepaid Health Clinic	OIR-C1-483http://www.flrules.org/Gateway/reference.asp?No=Ref-08305 (5/17) ~~(5/89)~~
(2)	Annual Reports	OIR-A2-949(07/04) and OIR-A2-950(07/04)~~482(1/90)~~
(3)	Authority to Release Information	OIR-C1-450(5/00) ~~(8/89)~~
(4)	Biographical ~~Statement and~~ Affidavit	OIR-C1-1423~~422~~(8/14)~~(8/89)~~
(5)	Abbreviated Biographical Statement	OIR-449(5/89)
(6)	Consent and Agreement in re Service of Process	OIR-C1-144(06/2004)~~(1/90)~~
(7)	Statement of Acquisition, Merger or Consolidation of a Specialty Insurer Pursuant to Florida Statutes 628.461, 628.4615.	OIR-C1-448(12/05)~~(5/89)~~
(8)	Fingerprint Payment and Procedure	OIR-C1-938(5/2013)
(9)	Instructions for Investigative Report	OIR-C1-905(2/15)

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

Rulemaking ~~Specific~~ Authority 641.403 FS. Law Implemented 624.424, 624.501(26), 641.402, 641.405, 641.41, 641.416 FS. History–New 6-25-90, Formerly 4-69.081, 4-194.030 Amended _____.

69O-207.001 Late Filed Reports - Fine Schedule.

(1) The following schedule of fines is hereby adopted by the Commission as a guideline in assessing fines against the referenced entities for the late filing of annual reports or statements as required by law:

Entity	A	B	Maximum Fine
(a) Continuing Care (651.026(1) and 651.015(2)(c))	$25 per day ~~and 50% of renewal fee~~	$50 per day ~~and 50% of renewal fee~~	None
~~(b) Preneed Funeral (639.10)~~	~~$12.50 per day each for Part I and Part II of Report~~	~~$25.00 per day for Part I and Part II of Report~~	~~None~~
(b)~~(c)~~ Health Maintenance Organizations (641.26(3))	$100 per day	$200 per day	$100,000
(c) ~~(d)~~ Prepaid Health Clinics (641.41(2))	$25 per day	$50 per day	None
~~(e) Prepaid Dental (637.423)~~	~~$12.50 per day~~	~~$25 per day~~	~~$1,000~~
~~(f) Ambulance Service (638.122(2))~~	~~$12.50 per day~~	~~$25 per day~~	~~$500~~
~~(g) Pharmaceutical Contracts (637.278(2))~~	~~$12.50 per day~~	~~$25 per day~~	~~$500~~
~~(h) Prepaid~~	~~$12.50 per day~~	~~$25 per day~~	~~$500~~

~~Optometric~~ (637.118(2))			
(d) ~~(i)~~ Multiple Employer Welfare Arrangements (624.442(5))~~(624.4211(2))~~	$100.00 per day	$200 per day	$2,500
(e) ~~(j)~~ Motor Vehicle Service Agreements ~~Automobile Warranty~~ (634.137)) (634.131(3))	$100 per day	$100 per day	None
(f) ~~(k)~~ Home Warranty (634.313(3))	$25 per day	$50 per day	None
(g) ~~(l)~~ Premium Finance (626.681)	$12.50 per day	$25 per day	$500
(h) ~~(m)~~ Prepaid Legal (642.0338(2))	$12.50 per day	$25 per day	$1,000
(i) ~~(n)~~ Service Warranty (634.415(3))	$50 per day	$100 per day	None
(j) ~~(o)~~ Insurance Administrators (626.894(2))	$12.50 per day	$25 per day	$1,000

"A" is applicable if the entity filed late last year and filed late this year, but within 5 days after notice or if timely filed last year and late by more than five days after notice in current year. "B" is applicable if the entity filed late last year and filed late in current year more than 5 days after notice.

(2) The fines provided in subsection (1) above may be increased or decreased based on the following mitigating and aggravating factors:

(a) Mitigating:

1. The entity has given advance notice to the Office that it will be filing late.

2. Justifiable unforeseen cause not within control of entity.

3. The entity has timely submitted major portions of the report.

4. Other mitigating factors as the Office may determine on the facts of the particular situation.

(b) Aggravating:

1. The entity has not given prior notice to the Office that it will be filing late.

2. Adverse financial condition indicated when report is filed.

3. Past violations by the entity.

4. Willfully or intentionally failing to file the report.

(3) The fines referenced in subsection (1) above are in addition to any other penalties that may be allowed by law, including the summary suspension of authority to transact business until the report is filed.

(4) For purposes of this rule an annual report or statement, required by law, is deemed received by the Office on the date it is submitted electronically at http://www.floir.com/iportal.~~postmarked by the official U. S. Postal Service Cancellation. Metered mail is not acceptable to meet this requirement. If metered mail is utilized or there is no official U. S. Postal Service Cancellation, the date stamped "received" by the Office will be deemed the date received.~~

Rulemaking ~~Specific~~ Authority 624.308(1),626.894,627.883,634.137, 634.021, 634.302, 634.402, ~~637.165~~, ~~637.325~~, ~~638.031~~, ~~639.08~~, 641.36, 641.403, 651.015 FS. Law Implemented 624.307(1), ~~624.4211(2),~~ 624.424, 624.442, 626.681, 626.894(2), ~~634.131(3),~~ 634.313(3), 634.415(3), 637.118(2), 637.278(2), 637.423, ~~638.122(2),~~ ~~639.10~~, 641.26(4)~~(3)~~, 641.41(2), 642.0338(2), ~~652.026(1)~~ FS. History–New 1-28-91, Formerly 4-120.001, 4-207.001 Amended_____.

69O-187.006 Deficit Assessments and Surplus Funds.

(1) through (2) No change

(3) All filings shall be submitted electronically to http://www.floir.com/iportal.

Rulemaking ~~Specific~~ Authority 627.357(6), 624.308(1) FS. Law Implemented 624.307(1), 624.424, 627.357 FS. History–New 10-7-75, Formerly 4-39.05, Amended 5-10-89, Formerly 4-39.005, 4-187.006, Amended _____.

69O-187.007 Continuing Requirements Including Filing of Reports and Rates.

(1) The Trustees shall have the accounts and records of the Fund audited annually or at any time as may be required by the Office, such audit to be made by Certified Public Accountants or by authorized representatives of the Office, with the Office reserving the right to prescribe a uniform accounting system to be used by the Fund in order that it may determine the solvency of the Fund. An audit prepared by other than Office personnel shall be a certified audit filed with and received by the Office in Tallahassee within ninety (90) days after the close of the fund year. All filings shall be submitted electronically to http://www.floir.com/iportal.

(2) The Trustees shall annually file a report as to financial condition, loss experience, and operational expense of the Fund on Form OIR-342 entitled "Medical Malpractice Self-Insurance Trust Fund Annual Audit". This report shall be due and must be received by the Office within ninety (90) days of the close of the fund year. Form OIR-342, rev. 2/93, is hereby adopted and incorporated by reference. Forms are available at http://www.floir.com/iportal. ~~Form OIR-342 may be obtained from and shall be submitted to the Office of Insurance Regulation, Bureau of Property and Casualty Forms and Rates, Larson Building, Tallahassee, Florida 32399-0300.~~

(3) No change

(4) Each Fund shall comply with Section 627.912, Florida Statutes, and Rule 69O-171.003, F.A.C., by filing Form OIR ~~DI4~~-303 entitled "Florida Medical Professional Liability Insurance Claims Report" which is incorporated by reference in rule 69O-171.003, with the Office. Form OIR-303 may be obtained from the Office of Insurance Regulation, Bureau of Property and Casualty Forms and Rates, Larson Building, Tallahassee, Florida 32399-0300.

(5) No Change

(6) The Fund shall file with the Office all changes or modifications to documents previously filed with the Office at least thirty (30) days prior to the date of implementation and all changes and modifications shall be subject to Office

approval. All filings shall be sumbitted electronically to http://www.floir.com/iportal.

(7) through (8) No change

(9) The Trustees shall file quarterly reports as to the financial condition, loss experience and operational expense of the Fund on Form OIR-343, "Medical Malpractice Self-Insurance Trust Fund Quarterly Audit", rev. 2/93, which is hereby adopted and incorporated by reference. This report is due and must be received by the Office within sixty (60) days of the close of the fund quarter. Forms are available at http://www.floir.com/iportal. ~~Form OIR-343 may be obtained from and shall be submitted to the Office of Insurance Regulation, Bureau of Property and Casualty Forms and Rates, Larson Building, Tallahassee, FL 32399-0300.~~

(10) No change

Rulemaking ~~Specific~~ Authority 624.308(1), 627.357(6) FS. Law Implemented 624.307(1), 624.424, 627.357, 627.4147, 627.4148 FS. History–New 10-7-75, Formerly 4-39.06, Amended 5-10-89, Formerly 4-39.006, Amended 1-18-94, Formerly 4-187.007, Amended_____.

69O-187.008 Contracts for Excess Insurance.

Specific excess and aggregate excess insurance may be required as a condition of approval or continuing operation of the Fund.

The Fund shall not voluntarily reduce its specific excess or aggregate excess insurance without the prior approval of the Office. The Fund shall notify the Office of any involuntary changes in such coverages as soon as the Fund receives notice of any such change in coverage. The Office may approve the continued operations of the Fund with the reduced coverage taking into consideration the availability of such excess insurance, the financial condition of the Fund and the cost of any such excess insurance. All filings shall be submitted electronically to http://www.floir.com/iportal.

Rulemaking ~~Specific~~ Authority 627.357(6)~~(3),~~ 624.308(1) FS. Law Implemented 624.307(1), 624.424, 627.357 FS. History–New 10-7-75, Formerly 4-39.07, Amended 5-10-89, Formerly 4-39.007, 4-187.008,

Amended_____.

69O-187.009 Termination or Merger of Self-Insurance Trust Fund

(1) No change

(2) For a voluntary termination or voluntary merger of the Fund, the Trustees shall:

(a) through (b) No change

(c) No change

1. through 2a. No change.

b. The Office shall exempt the Fund from the requirements of sub-subparagraph (2)(c)2. a., if the Fund demonstrates that the purchase through competitive bidding of an appropriate insurance product relieving the Fund of any liabilities incurred while operating pursuant to Section 627.357, Florida Statutes, is in the best interest of the Fund and that the provider of the product is an insurer authorized to transact insurance in this state.

3. For a merger:

a. The Fund shall submit a request for a Loss Portfolio Transfer All filings shall be submitted electronically to http://www.floir.com/iportal. ~~on Form OIR-LPT, "Medical Malpractice Self-Insurance Trust Fund Application for Loss Portfolio Transfer," rev. 7/93, which is hereby adopted and incorporated by reference. The form may be obtained from and shall be submitted to the Bureau of Property and Casualty Forms and Rates, Division of Insurer Services, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0300.~~

b. through c. No change

(3) No change

Rulemaking ~~Specific~~ Authority 624.308(1), 627.357(6) FS. Law Implemented 624.307(1), 624.424(6), 627.357 FS. History–New 1-18-94, Formerly 4-187.009 Amended_____.

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

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

(2) through (3) No change

Rulemaking Authority 624.308(1) FS. Law Implemented 624.424, 624.307(1), 626.9541(1)(o)3.a., 627.420, 627.421, 627.728, 627.7282 FS. History–New 7-23-88, Amended 9-18-90, Formerly 4-28.005, 4-167.002 Amended_____.

69O-157.111 Reporting Requirements.

(1) No change

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

(3) No change

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

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

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

(7) through (8) No change

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

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

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

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

STATEMENT OF ACCOUNT

Please send this form to the insured upon cancellation, for each policy.

Name of Insured _____

Name of Insurance Company----------

Name of Insurance Agent----------

Name of Finance Company----------

Account Number---------- Cancellation Date_____

Policy Effective Date------- Expiration Date-------

(1)	Quoted Gross Premium	_____
(2)	Additional Premium Financed (if any)	(+) ---- --
(3)	Finance Charge	(+) ------
(4)	Documentary Stamps	(+) _------____
(5)	Total of Payments Due	(=)_____--
(6)	Total Payments Received from Insured	(-) ------
(7)	Late Fees (if any)	(+) ------
(8)	Set up Fee (if any)	(+) ------
(9)	Balance Due Finance Company	(=)_____
(10)	Amount received from Insurance Company	(-)_____
(11)	Amount received from Insurance Agent	(-)_____
(12)	Balance due Finance Company <Insured>	(=) _____

(If item 12 is Negative, indicate whether the refund was sent to the Agent ___ or to the Insured ; and the date of return: _____ _____.)

(If item 12 is Positive, indicate whether the balance is due from the Agent for unearned commission $; from the Insurer for unearned premium $_____; or from the insured $.)

Signature of Preparer_____

Name and Title (Print)_____Date_____

OIR-A3-~~DI~~4-970 (11/91)
Rule 69O-196.025

Department of Financial Services
Office of Insurance Regulation

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

1. Acquiring Company:

_____
(Name)

_____
(Address)

_____
(City, State, Zip)

_____
(Telephone Number)

_____
(Federal Identification Number)

_____
(Contact Person)

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

_____

_____
(Type of Certificate of Authority)

_____
(Name)

_____
(Address)

_____
(City, State, Zip)

_____
(Telephone Number) (Fax Number)

_____
(Federal Identification Number)

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

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

4. Check one or both of the following:

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

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

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

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

_____

_____

_____

_____

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

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

   Provide documentation to support this information was received.

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

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

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

i) Liquidate the Specialty Insurer? ____ Yes ____ No

ii) Sell its assets? ____ Yes ____ No

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

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

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

b) Does the acquiring person plan to:

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

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

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

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

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

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

If "NO", explain.

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

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

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

13. For HMOs only:

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

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

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

EXHIBITS

1. All written agreements between parties.

2. Summary of any verbal agreements between parties including:

a) Any transfer of securities?

b) Any option arrangements?

c) Any puts or calls?

d) Any proxies given or received?

3. Description of the transaction including:

   a) Controlling interest;

   b) Terms of the acquisition;

   c) Number and percentage of shares to be acquired;

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

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

5. Evidence that all required reserves are in place.

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

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

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

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

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

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

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

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

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

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

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

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

17. Other (identify and explain):

The Following Attestation Form Shall Be Used:

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

(Corporate Seal)

_____
(Typed Name and Title)

State of_____

_____
(Signature)

County of _____

Sworn to and subscribed before me

this _____ day of _____ , 20_____

_____
(Notary Public)

(Seal)

My Commission Expires _____

WAIVER OF PUBLIC HEARING AND REQUEST FOR APPROVAL

We, the undersigned, on behalf of _____

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

_____ by _____

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

Date: _____

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

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

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-203.100
69O-191.107
OIR-C1-144
Rev 06/2004

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

Office of Insurance Regulation
Life & Health Financial Oversight

SWORN STATEMENT IN LIEU OF ANNUAL STATEMENTS FOR ISSUERS OF DONOR ANNUITY AGREEMENTS

Donor Annuity Issuer's Name: _____

Street: _____

City: _____ State/Prov: _____ Zip/Postal: _____

Phone: Ext: _____ Fax: _____

Email Address: _____

Donor Annuity Issuer's Contact Person: _____

Donor Annuity Issuer's FEIN: _____

STATE OF: _____

COUNTY OF: _____

_____, _____ (both printed please), of the above named issuer, being duly sworn, each deposes and says that they are the above described officers of the said issuer, and that on _____, which is the fiscal year-end, the issuer has met all of the requirements of Section 627.481, FS., and Chapter 69O-202, Florida Administrative Code.

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

HEALTH MAINTENANCE ORGANIZATION

Annual Report Filing Fees

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

(Name of HMO)

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

_____ ATTACH YOUR CHECK HERE

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

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

OFFICE OF INSURANCE REGULATION
Life & Health Product Review

INDIVIDUAL CARRIER'S APPLICATION TO BECOME A RISK ASSUMING CARRIER OR A REINSURING CARRIER, AS REQUIRED BY SECTION 627.6475(5), FLORIDA STATUTES

CARRIER NAME _____

ADDRESS (Street) _____

(City, State Zip) _____

FEIN: _____ NAIC GROUP CODE: _ NAIC COMPANY CODE: _

As required under the provisions of Section 627.6475(5), Florida Statutes, we hereby apply to elect the following status. Select one block only.

☐ **A. Reinsuring Carrier**

A reinsuring carrier is a direct writer of individual health insurance and participates in the health reinsurance program created by Section 627.6475(7), Florida Statutes. If reinsuring carrier status is elected, nothing further is required except completion of the signature line on page 2 and submission to the Office, Bureau of Life and Health Forms and Rates.

☐ **B. Risk Assuming Carrier**

If risk-assuming carrier status is elected, attach information showing that the carrier is financially capable of assuming that status pursuant to the criteria in items 1 through 4, below; then complete the signature line at the bottom of the page and send to the Office, Bureau of Life and Health Forms and Rates.

1. The issuer's financial ability to support the assumption of risk of individuals. The issuer shall demonstrate that its surplus is adequate to support the fair marketing required by statute and that the planned premium volume after becoming a risk- assuming carrier does not endanger the financial condition of the issuer or endanger the interest of the enrolled individual.
2. The issuer's history of rating and underwriting. The issuer shall demonstrate that it has successfully engaged in the business of transacting rating and underwriting of individuals, or is the wholly owned subsidiary of such a company and that its condition and methods of operation in connection with individual contracts will not be such as to render its operation hazardous to the public or its policyholders in this state.
3. The issuer's commitment to market fairly to all eligible individuals in the state or its service area, as applicable. The issuer shall include a statement that the applicant has read and will comply with Section 627.6475(8), Florida Statutes, Standards to Assure Fair Marketing. The Office shall consider the character, responsibility and general fitness of the officers and directors and the past market conduct of the carrier or its representatives.
4. The issuer's ability to assume and manage the risk of enrolling individuals without the protection of the reinsurance program provided by Section 627.6475(7), Florida Statutes. The Office shall consider the history and financial condition of the company. It should be demonstrated that the financial condition of the issuer is adequate to assume the risk of marketing to individuals regardless of their claims experience or their health status. If part of the response is that your existing reinsurance program will be depended upon to cover such risks that you may be required to assume, include a copy of the reinsurance treaty with a summary of how it applies to these risks. The requirement of a copy of the reinsurance treaty does not apply to carriers that have a policyholder surplus in excess of $100,000,000.

☐ **C. Company will not market or issue. Company will not market or issue individual health insurance to eligible individuals in Florida after December 31, 1997. Should you desire to later participate in this market, an application will be required.**

_____ _____
Signature of Officer Date

_____ _____
Name of Officer Position or Title

PLEASE TYPE OR PRINT DATE, POSITION OR TITLE, AND NAME OF OFFICER

Form OIR-B2-1311 to be submitted as follows:

Office of Insurance Regulation
Life & Health Product Review
Larson Building,
Tallahassee, FL 32399-0328

69O-154.115
OIR-B2-1311
Rev. 8/03

FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of_____

By

_____

Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____, 20____

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

_____

_____

_____

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

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

ITEM 2. ORGANIZATIONAL CHART

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

ITEM 3. THE ULTIMATE CONTROLLING PERSON

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

(a) Name;

(b) Home office address;

(c) Principal executive office address;

(d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.;

(e) The principal business of the person;

(f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned; and

(g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

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

ITEM 5. TRANSACTIONS AND AGREEMENTS

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

(a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;

(b) Purchases, sales or exchanges of assets;

(c) Transactions not in the ordinary course of business;

(d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the registrant's business;

(e) All management agreements, service contracts and all cost-sharing arrangements;

(f) Reinsurance agreements;

(g) Dividends and other distributions to shareholders;

(h) Consolidated tax allocation agreements; and

(i) Any pledge of the registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

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

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

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

ITEM 6. EMPLOYMENT CONTRACTS

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

ITEM 7. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

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

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

ITEM 8. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

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

ITEM 9. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

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

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

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

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

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

ITEM 10. FORM C REQUIRED

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

ITEM 11. SIGNATURE AND CERTIFICATION

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

_____	_____	_____
Date	Name	Position or Title

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

[SEAL]

_____
Notary Public

NOTE: THIS FORM AND METHOD OF PAYMENT FOR USE ONLY BY NON-U.S. CITIZENS WITH NO SOCIAL SECURITY NUMBER -ALL OTHER APPLICANTS SEE OIR-CI-938 FOR FINGERPRINT PROCESSING PAYMENT INSTRUCTIONS

OFFICE OF INSURANCE REGULATION
Company Admissions

INVOICE FOR NON-U.S. CITIZENS WITH NO SOCIAL SECURITY NUMBER

REQUEST FOR PAYMENT OF FINGERPRINT CHARGES

NAME OF COMPANY: _

FEIN: _

Address_____

_____
CITY STATE ZIP CODE

ADDRESS (IF DIFFERENT FROM COMPANY ADDRESS)

_____

_____
CITY STATE ZIP CODE

In reference to the recent submission by the above referenced insurer regarding the fingerprint cards requested on each officer and/or director, it is necessary that this form and the fingerprint cards be returned with the proper payment as listed below for the processing of these cards.

PLEASE NOTE:

1. Send a check in the proper amount payable to the Florida Department of Financial Services and **mail check and invoice only** to the Department of Financial Services, Bureau of Financial Services, Post Office Box 6100, Tallahassee, Florida 32314-6100.

2. Send fingerprint cards, a **copy** of the check and invoice along with the completed application package to the Florida Office of Insurance Regulation, Company Admissions, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0332.

B/T	TY/CL	F/T
C	1002	F

FEE SCHEDULE:
Number of Cards_____@ $64.00 per person ... $_____

Attach list of individuals for whom fingerprint cards are submitted with this invoice.

69O-203.100
OIR-C1-903
REV 12/05

Office of Insurance Regulation
Company Admissions

INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS

1. A background investigative report must be completed for each individual as indicated in the instructions in the application package.

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

3. The applicant is responsible for paying for the reports and for handling billing arrangements with the selected vendor.

4. Applicants are required to ensure that the selected vendor will transmit investigative reports electronically to the Florida Office of Insurance Regulation ("Office") to this e-mail address: bkgrnd-inv@floir.com in Microsoft Word format, with appropriate reference to the applicant in the subject of each transmittal e-mail. Reports should be submitted prior to or contemporaneously with the submission of each application filing, with the exception of acquisition filings.

6. Applicants must include evidence indicating that background reports have been ordered, including proof of payment, as a component in the online submission via iApply.

7. Any questions regarding this process may be directed to the Office at appcoord@floir.com

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

I,_____, presently resident at

_____ and am affiliated with or proposed to be affiliated with

_____ which is applying for licensure or a permit to organize

by the Office of Insurance Regulation.

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

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

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

_____ _____

Applicant's Signature Date

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

1._____ 2. _____

State of _____

County of _____

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

_____

Notary Public

(Notary Seal)

My Commission Expires:

69O-191.107 69O-192.058

OIR-C1-450
REV(5/00)

Office of Insurance Regulation
Company Admissions

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

LiveScan (available to Florida Residents):

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

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

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

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

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

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

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

Payment confirmations will be a required component in the electronic application submitted via Apply. Questions may be emailed to appcoord@floir.com.

)O-191.107
'O-192.058
R-C1-938
?013

CONFIDENTIAL

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

Applicant's Name: _____

Applicant's Social Security Number: _____

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

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

CONFIDENTIAL

APPLICATION FOR CERTIFICATE OF AUTHORITY MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

This package is designed to assist individuals in preparing the application with all the information required by statute and facilitate expeditious processing of the application by the Office of Insurance Regulation. This package includes five (5) categories of information:

Section I - Application Fees and Form
Section II - Legal
Section III - Financial and Related Information
Section IV - Management
Section V - Forms and Rates

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

Please submit your package tabularized in a binder that has been two-hole punched at the top and place tabs at the bottom of the documents. (Example: the tab labeled II-1 would contain the certified Articles of Incorporation).

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

It is recommended that, prior to filing the application, you schedule a pre-filing conference with the Bureau of Life and Health Solvency to go over particular problems encountered in the past. Although the pre-filing conference is not a statutory requirement, it has proven beneficial to both the applicant and the Office of Insurance Regulation. To schedule a conference, please call the Applications Coordination Section at (850) 413-2570.

Once the application is complete, mail it to:

Office of Insurance Regulation
Applications Coordination Section
200 East Gaines Street
Tallahassee, Florida 32399-0332

IN ORDER FOR A SUBMISSION TO BE CONSIDERED A COMPLETE APPLICATION, ALL REQUIRED INFORMATION MUST BE INCLUDED IN THE FILING. FILINGS THAT DO NOT INCLUDE ALL REQUIRED INFORMATION WILL BE DISAPPROVED OR RETURNED.

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
MANAGEMENT INFORMATION FORM
COMPLETE LISTING OF INCORPORATORS, OFFICERS
DIRECTORS, AND SHAREHOLDERS (10% OR MORE)

INCORPORATORS:

TITLES:

OWNERSHIP PERCENTAGE:

OFFICERS:

DIRECTORS:

SHAREHOLDERS:

STATE OF FLORIDA
DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
TALLAHASSEE, FLORIDA 32399-0300
BIOGRAPHICAL STATEMENT AND AFFIDAVIT

All questions on this form should be answered fully. If more space is needed, attach additional sheets. If a question is not applicable, please pu
Applicable" or "N/A". Please print or type all answers.

QUESTIONS

1. (a) Full Name _____ (b) Maiden Name _____

   (c) Date of Birth _____ (d) Place of Birth _____

   (e) Social Security Number _____ (f) Occupation or Profession _____

2. Full name, address, and telephone number of the present or proposed entity for which this biographical statement is being required.

3. Type of entity (i.e. insurance company, health maintenance organization, premium finance company, CCRC, etc.):

4. Your current or proposed position with the present or proposed entity.

5. List your residence for the last ten (10) years starting with your current address and going backward, giving:

Dates	Address	City, County, State	Telephone

6. Education. Please list the most recent education first.

(a) College/University	Dates Attended	Type of Degree Obtained

(b)Other Training

'R-C1-422
:V 10/26/98
)-192.058

STATE OF FLORIDA
OFFICE OF INSURANCE REGULATION

7. (a) Business and employment record for past ten (10) years. Please list the most recent first. Include all director and officer positions held, including current position.

Dates	Employer's Name	Address & Telephone	Offices/Positions Held

(b) May present employer be contacted? Yes ___ No ___

8. List all other current business activities:

9. (a) Have you or your spouse ever been affiliated or associated with or in any way connected with an insurance entity regulated by the Florida Department of Insurance or any other state? Yes ___ No ___

(b) If "Yes", please list all such entities:

10. (a) Do you or members of your immediate family have or expect to have an ownership interest of any kind in the present or proposed entity? Yes ___ No ___

(b) If "Yes", list all such ownership interests and give full details. If the ownership interest is pledged or hypothecated in any way, give full details.

11. (a) Have you ever used any other name or an alias? Yes ___ No ___

(b) If "Yes", list all other names used and give full explanation.

12. (a) Have you ever been bonded? Yes ___ No ___

(b) If "Yes":

1. Were any claims ever made or attempted to be made against your bond? Yes ___ No ___
2. Has your bond ever been canceled or revoked? Yes ___ No ___
3. Has your application for bond been declined? Yes ___ No ___
4. If the response to 1, 2, or 3 is "Yes", please provide reasons.

13.(a) Have you ever been licensed as an insurance agent, broker, solicitor, adjuster, or claims investigator in Florida or any other state? Yes ___ No ___

(b) If "Yes":

1. State(s) _____
2. Dates license(s) held _____
3. License number(s) _____
4. Name of issuer of license(s) _____

14. (a) Have you ever been licensed to sell securities? Yes ___ No ___

(b) If "Yes":

1. By whom (state[s] and/or federal) _____
2. Dates license(s) held _____
3. License number(s) _____
4. Name of issuer of license(s) _____

15. List any other occupational, professional, or vocational licenses you have ever held and identify the state(s), the dates license(s) held, type of license, and the license number(s). Identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued.

_____

_____

16. List any entities regulated by the Office of Insurance Regulation in which you control directly or indirectly or own legally or beneficially ten (10) percent or more of the outstanding stock (in voting power).

_____

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

_____

17. List memberships in professional societies and associations: _____

18. (a) Are you a citizen of any country other than the United States? Yes ___ No ___

If Yes, what country? _____

(b) Have you ever violated any of the U.S. Immigration and Naturalization laws? Yes ___ No ___

19. (a) Have you ever:

(1) Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public, administrative, or governmental licensing agency? Yes ___ No ___

(2) 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 ___

(3) 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 ___

(4) Been charged with, or indicted for, any criminal offense(s) other than minor traffic offenses(s)? Yes ___ No ___

(5) Pled guilty, or nolo contendere, or been convicted, of any criminal offense(s) other than minor traffic offenses? Yes ___ No ___

(6) 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 minor traffic offenses? Yes ___ No ___

(7) Been subject to any federal bankruptcy proceeding, state insolvency, supervision, receivership, rehabilitation, liquidation, or conservatorship proceeding, or any other similar proceeding? Yes ___ No ___

(8) 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 or state law regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? Yes ___ No ___

(9) Been, within the last ten (10) years, a party to any civil action other than for minor traffic offenses? Yes ___ No ___

(10) Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provision 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 ___

(11) Had a lien, judgment or foreclosure action filed against you or any entity while you were associated with that entity? Yes ___ No ___

(b) If the response to any question in #19 above is answered "Yes", please provide full details including dates, locations, dispositions, etc. (Attach a copy of the complaint and final adjudication or settlement as appropriate.)

_____

_____

20. (a) For the purpose of this question, if you hold or have held any of the following positions with any entity whether regulated or not regulated by the Office of Insurance Regulation, please indicate below:

1. Incorporator or organizer Yes ___ No ___
2. Administrator, manager or operator Yes ___ No ___
3. Subscriber of a corporation, reciprocal, or limited reciprocal Yes ___ No ___
4. Director, officer, or trustee Yes ___ No ___
5. Owner, if not a corporation, sole proprietor Yes ___ No ___
6. Partner, including all general and limited partners of a limited partnership, joint venturer Yes ___ No ___
7. Stockholder owning or holding ten (10) percent or more of the outstanding stock of a stock corporation Yes ___ No ___
8. Member of a non-stock corporation Yes ___ No ___
9. Person associated or to be associated with the formation or financing of an underwriting member on an Insurance Exchange in any state or country Yes ___ No ___
10. Attorney-in-fact or attorney for a reciprocal insurer or a limited reciprocal insurer Yes ___ No ___
11. Any position, other than one listed above, which you held in an insurance related entity Yes ___ No ___

If the response to any question in #20 (a) above is answered "yes", please provide full details.

_____

_____

20. (b) To your knowledge, has any entity while you were associated with that entity or within twelve (12) months after you left:

1. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental licensing agency? Yes ___ No ___
2. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, investigated, or subjected to any judicial, administrative, regulatory, or disciplinary action? Yes ___ No ___
3. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any judicial, administrative, regulatory, or disciplinary action? Yes ___ No ___
4. Been charged with, or indicted for, any criminal offense? Yes ___ No ___

STATE OF FLORIDA
OFFICE OF INSURANCE REGULATION

5. Pled guilty to, or nolo contendere to, or been convicted of any criminal offense? Yes ___ No ___

6. Had an 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? Yes ___ No ___

7. Been insolvent or impaired? Yes ___ No ___

8. Been subject to any federal bankruptcy proceeding, state insolvency, supervision, receivership, rehabilitation, liquidation, or conservatorship proceeding, or any other similar proceeding? Yes ___ No ___

9. Been enjoined, either temporarily or permanently, in any judicial, administrative, regulatory or disciplinary action from violating any federal or state law regulating the business of insurance, securities, or banking, or from carrying out any particular practice or practices in the course of business insurance, securities, or banking? Yes ___ No ___

10. Been within the last ten (10) years a party to any civil action? Yes ___ No ___

If the response to any question above in # 20 (b) is answered "Yes", please provide full details below:

_____

_____

_____

I HEREBY CERTIFY, under penalty of perjury, that the foregoing answers, statements, and information are true and correct to the best of my knowledge.

I, the undersigned affiant, under penalty of perjury, do declare that I have carefully examined each of the questions asked in this BIOGRAPHICAL STATEMENT AND AFFIDAVIT and each of my responses thereto, and do solemnly swear or affirm that all of my responses, information, exhibits, and documentary evidence submitted in support thereof are true and correct.

_____
(Typed Name)

_____
(Signature)

_____
(Date)

State of _____

County of _____

BEFORE ME this day personally appeared _____ (Typed name of Affiant) who, being duly sworn, deposes and says that he/she executed the above BIOGRAPHICAL STATEMENT AND AFFIDAVIT and that the answers, statements, and information contained in this statement are true and correct.

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

(Notary Seal)

_____
Notary Public

My commission expires: _____

PLEASE DO NOT RETYPE THIS BIOGRAPHICAL FORM

OFFICE OF INSURANCE REGULATION
Company Admissions

NOTIFICATION TO THE OFFICE OF INSURANCE REGULATION AS A QUALIFYING ISSUER OF DONOR ANNUITY AGREEMENTS PURSUANT TO SECTION 627.481, FLORIDA STATUTES (FS)

Donor Annuity Issuer's Name: _____

Address: _____

_____

City: _____ ***State:*** _____ ***Zip:*** _____

Phone: ( ) _ ***Fax:*** ( ) _

Email Address: _____

Fiscal Year-end: _____

State of Domicile: _____

Donor Annuity Issuer's Contact Person: _____

Donor Annuity Issuer's FEIN: _____

represented by _____ _____
(name) (position)

and _____ _____
(name) (position)

hereby notify the ***Office of Insurance Regulation*** and say by action of its trustees, and as represented by the two officers/directors with board voting privileges that the issuing entity intends to enter into donor annuity agreements in the State of Florida as allowed by Section 627.481, FS.

The Representatives certify that the Issuer **(check one):**

a) ☐ has been in active operation for at least five years prior thereto and has qualified as an exempt organization under the Internal Revenue Code, 26 U.S.C. s. 501(c)(3); OR

b) ☐ has been wholly controlled for at least 10 years by a corporation or trust qualified under paragraph (a), if the subunit has been a corporation or trust for at least 2 years, and has engaged in the selling of annuity agreements authorized under this section in at least three other states without complaint.

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

The Representatives further certify that:

1) All annuity benefits will be calculated to return to the Issuer upon the death of the donor a residue at least equal to one-half the original gift or other consideration under any such donor annuity agreement issued under Section 627.481, FS.

2) The Issuer will maintain admitted assets at least equal to the sum of the reserves on its outstanding donor annuity agreements, and a surplus of 10 percent of such reserves, calculated pursuant to Sections 627.481(2)(a) 1–3, FS, less any properly reinsured annuity risk.

3) The Issuer in an amount at least equal to the sum of such reserves and surplus will invest only in mutual funds or investments permitted under part II of chapter 625, FS, pursuant to the conditions of Section 627.481(2)(c) 2, FS, and such assets are segregated as separate and distinct funds, independent of all other funds and not applied for the payment of the debts and obligations of the Issuer for any other purpose other than the annuity benefits specified in Section 627.481, FS. Foreign Issuers may invest in the kind of securities permitted by the laws of the state in which incorporated or organized.

4) All donor annuity agreements issued will contain the clause: "This annuity is not issued by an insurance company, is subject only to limited regulation by the State of Florida and is not protected or otherwise guaranteed by any government agency."

5) Any donor annuity agreements entered into by the Issuer to support state institutions of higher learning will contain the clause: "This agreement is the entire contract between the parties, with rights and responsibilities of each party to the other as set forth herein. The donor or annuitant shall not have recourse against any assets of the state other than any funds or assets donated by, or funds derived from any assets donated by, the donor as set forth herein."

6) Charitable remainder unitrust trusts, charitable remainder annuity trusts, charitable lead trusts, pooled income funds or other similar charitable split interest trusts are only exempt from subsections (1), (2), (3), and (5), of Section 627.481, FS. and;

7) Provisions of part IX of Chapter 626, FS, known as *Unfair Insurance Trade Practices*, apply to issuers of donor annuity agreements under Section 627.481, FS.

The Representatives certify the Issuer is in compliance with all statutes governing the issuance of donor annuity agreements in the State of Florida.

for the ***Issuer***

BY: _____ , DATED: _____
(signed)

BY: _____ , DATED: _____
(signed)

(CORPORATE SEAL)

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

ANNUAL REPORT

DAMAGE CLAIMS & MEDICAL INJURY

MANAGED CARE COMPANY: _____

YEAR ENDING: _____

The number and amount of damage claims for medical injury initiated against the health entity and any providers engaged by it during the reporting year. [HMOs-641.26(1)(e), F.S.; PHCs-641.41(1)(e); PLHSOs 636.043(2)(d)]

Number of Claims	_____
Total Dollar Value of Claims	_____
Number of Claims Without Legal Process	_____
Number of Claims Disposed (Settled, or Otherwise Discharged)	_____

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

ANNUAL REPORT

CONTRACTS ISSUED & OUTSTANDING

MANAGED CARE COMPANY: _____

YEAR ENDING: _____

Number of health contracts issued and outstanding and number terminated.
[HMOs-641.26(1)(d), F.S.; PHCs-641.41(1)(c), F.S.; PLHSOs-636.043(2)(c), F.S.]

Group subscriber contracts issued and outstanding _____

Individual subscriber contracts issued and outstanding _____

Group subscriber contracts terminated _____

Individual subscriber contracts terminated _____

69O-191.107
69O-203.100
OIR-A2-949
07/04

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

The Health Maintenance Organization's Application for Certificate of Authority requires five (5) categories of information:

Section I	Application Fees and Form
Section II	Legal
Section III	Financial and Related Information
Section IV	Management
Section V	Forms and Rates

It is important to complete each section in the specified format without omitting any requested information.

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

Submit the completed application package to:

Department of Financial Services
Office of Insurance Regulation
Applications Coordination Section
200 East Gaines Street, Room 131
Tallahassee, Florida 32399-0332

IN ORDER FOR A SUBMISSION TO BE CONSIDERED A COMPLETE APPLICATION, ALL REQUIRED INFORMATION MUST BE INCLUDED IN THE FILING. FILINGS THAT DO NOT INCLUDE ALL REQUIRED INFORMATION WILL BE DISAPPROVED OR RETURNED.

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

Pursuant to Section 641.2015 and 641.19, Florida Statutes, in order to qualify as a Health Maintenance Organization, an entity must:

A. Be incorporated or be a division of a corporation formed under the provisions of either chapter 607 or Chapter 617, or shall be a public entity that is organized as a political subdivision. [s. 641.2015, F.S.];

B. Provide emergency care, inpatient hospital services, physician care including care provided by physicians licensed under Chapters 458, 459, 460, and 461, ambulatory diagnostic treatment, and preventive health care services. [s.641.19(7)(a), F.S.];

C. Provide either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis. [s.641.19(7)(b), F.S.];

D. Provide either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract. [s.641.19(7)(c), F.S.];

E. Provide physician services, by physicians licensed under Chapters 458, 459, 460 and 461, directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians. [s.641.19(7)(d),F.S.]; and

F. If an HMO offers services through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or Chapter 459 and Chapters 460 and 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the health maintenance organization's provider network [s.641.19(7)(e), F.S.]

Although a pre-filing conference is not a statutory requirement, it has proven beneficial to both the applicant and the Office. To schedule a conference, please call the Applications Coordination Section, Office of Insurance Regulation, (850) 413-2570.

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORM

Section I-11 **Application Fee**

The application filing fee is $1,000. [s.641.29(1),F.S.]

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

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

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

Section I-2 **Fingerprint Processing Fees**

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

Secure the check to the enclosed invoice and mail to:

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

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

Section I-3 **Deposits and Assessments**

A. Submit a check for $10,000 made payable to " Director of Insurance Regulation, State of Florida-Rehabilitation Administrative Expense Fund" to comply with Section 641.227(1), Florida Statutes. Mail the check to:

Department of Financial Services
Revenue Processing Section
PO Box 6100
Tallahassee, Florida 32314-6100

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

B. Submit a check for $25,000 made payable to "Florida HMO Consumer Assistance Plan" to cover the special assessment required by Section 641.228(1), Florida Statutes. Mail the check to:

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

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

Section I-4 **Application for Certificate of Authority (Official Form Attached)**

An original signature by the president or chief executive officer and one other authorized officer must appear on the application form under corporate seal.

SECTION II - LEGAL

Section II-1 Articles of Incorporation

Submit Articles of Incorporation and all amendments certified by the Florida Secretary of State's office. The certification must be an original.

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

Submit an original certificate of status by the Florida Secretary of State's office demonstrating that the company is in good standing. You may contact the Florida Secretary of State's office at (850) 245-6052 for further information in obtaining this certificate.

Section II-3 Company Bylaws

Submit a copy of the company's bylaws, rules and regulations or similar form of document, if any, regulating the conduct of the affairs of the applicant. These documents must be accompanied by a Board Resolution signed and dated by the secretary of the corporation, stating that the documents are a true and correct copy. The signature must be original and under the company's corporate seal.

Section II-4 Health Care Provider Certificate

Submit documentation demonstrating that the entity has filed an application for a Health Care Provider Certificate to be issued by the Agency for Health Care Administration (AHCA) pursuant to Chapter 641, Part III, Florida Statutes. Documentation may be provided in the form of an acknowledgement from the Agency for Health Care that the application has been received by them.

NOTE: The Office will begin its review of an application for a Certificate of Authority any time after an organization has filed an application for the certificate with the Agency for Health Care Administration. The Office shall not issue a Certificate of Authority to any applicant, which does not possess a valid Health Care Provider Certificate. Once the Health Care Provider Certificate is issued, a copy must be provided to the Office of Insurance Regulation.

Section II-5 Authorization Letter

A letter of Authorization is required for anyone other than company personnel or the company sponsoring agent, designating the named individual to represent the applicant.

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Insurance

A. Furnish evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising from the provision of health care services. If not self-insured, submit executed copies of the following policies, with the Office of Insurance Regulation listed on the policies for purposes of notification of any modification, cancellation or termination of the policies:

(1) General liability

(2) Medical malpractice or professional liability. The HMO must secure this coverage. The fact that the medical provider has this coverage does not release the HMO from the obligation to secure it. A binder for the policies along with a specimen copy of each policy can be submitted initially. Prior to licensure, executed copies of the policies must be submitted.

B. Furnish a photocopy of an executed fidelity bond in the minimum amount of $100,000, issued by an **authorized insurance carrier** in this State and covering all employees handling funds.

C. Describe how the HMO limits or proposes to limit its financial risk. If the HMO secures catastrophic or reinsurance coverage, it is required to submit executed copies of the applicable policy with the Office of Insurance Regulation endorsed on the agreement as an additional insured.

NOTE: Describe any risk sharing arrangements with providers or any other parties. Reference by application page number, the application sections of any provider contracts, which demonstrate the sharing of risk between the HMO and providers.

Section III-2 Financial Statements

A. Provide a copy of the most recent audited certified public accountant's report prepared on the basis of statutory accounting principles. If the applicant is a development stage company that has not begun operations, an audited balance sheet should be provided. The financial statements should reflect sufficient surplus to meet the requirements of s. 641.225, Florida Statutes.

B. Provide all quarterly financial statements covering the current year-to-date reporting period signed by the company's officers under notary seal.

Section III-3 Plan of Operations

Provide a statement generally describing present and proposed operations. State whether the HMO will be organized for profit or not for profit and whether it will be a Staff Model, IPA Model, or Combination Model HMO. Also, identify the HMOs fiscal year end date. The plan of operations should be for the greater of three years or until the health maintenance organization has been projected to be profitable for twelve consecutive months.

If the HMO intends to market to small groups as defined by the Employee Health Care Access Act, s. 627.6699, Florida Statutes, please complete and submit the attached small employer carrier's application.

If the plan of operation indicates that the HMO will receive Medicaid funds, list all contracts and agreements and any information relative to any payment or agreement to pay, directly or indirectly, a consultant fee, a broker fee, a commission, or other fee or charge related in any way to the application for a certificate of authority or the issuance of a certificate authority. Such list shall provide the following, including, but not limited to, the name of the person or entity paying the fee; the name of the person or entity receiving the fee; the date of payment; and a brief description of the work performed.

Section III-3(a) Marketing and Growth

Submit a description of the proposed method of marketing, including the target groups, types of coverage to be offered, and advertising media to be used. Include a statement describing with reasonable certainty the geographic area or areas to be served by the HMO. Identify competing HMOs operating in the same geographic service area, as well as the market penetration of each. Also, identify the major differences between the applicant HMO and its competitors.

Section III-3(b) Pro Forma Statements

Submit a pro forma balance sheet and income statement on a statutory basis at monthly intervals (with an annual total) for a minimum three-year period (greater of three years or until the health maintenance organization has been projected to be profitable for twelve consecutive months.) All assumptions used in deriving the pro forma statements must be provided. A Statement of Changes in Financial Position and a Statement of Cash Flows should be provided for the three-year period (or break-even), as well.

Section III-3(c) Statement of Initial Cash

Submit a statement of the proposed initial cash and cash reserves summary, including loan receipts, loan repayments, stock sales, etc. Also, describe the sources and terms of the funding. In the case of guaranteeing organizations, audited financial statements should be submitted for these entities.

Section III-3(d) History

Provide a brief history of the company since its incorporation. Include any predecessor corporations or organizations, mergers, reorganizations, or changes of ownership. Specify the parties and dates involved.

Section III-3(e) Insolvency Protection

Provide the method in which the applicant will comply with the insolvency protection requirements of Section 641.285, Florida Statutes, including all relevant documentation necessary to meet the requirements. Each HMO must comply with the insolvency protection requirements of Florida law. This is accomplished through a deposit with the Office of Insurance Regulation in the amount of $300,000.00.

Section III-3(f) Contingency Plans

Provide any contingency plans for additional capital should the HMO fail to maintain minimum surplus requirements as mandated by Section 641.225, Florida Statutes.

Section III-3(g) Feasibility Study

Submit a comprehensive feasibility study, performed by a certified actuary in conjunction with a certified public accountant, which includes a rate and financial analysis, as well as enrollment projections and assumptions and competitor information. The study shall be for the greater of three years or until the HMO has been projected to be profitable for twelve consecutive months. The study shall show that the HMO will maintain, at all times, the minimum surplus required by Section 641.225, Florida Statutes, and will not, at the end of any month of the projection period, have less than the minimum surplus as required by Section 641.225, Florida Statutes. The feasibility study shall contain an opinion by the CPA and actuary performing the study which shall opine as to the reasonableness of the assumptions used in the feasibility study and that the assumptions are reasonably applied.

The financial portion of the study shall be prepared in accordance with standards promulgated by the American Institute of Certified Public Accountants in its "Guide for Prospective Financial Statements" and opined accordingly. The actuarial portion of the study shall be prepared in accordance with standards promulgated by the American Academy of Actuaries and opined accordingly. The feasibility study shall contain nothing less than an "examination opinion."

Section III-4 Contracts

A. A copy of each type of contract made, or to be made, between the applicant and any providers (i.e hospitals, physicians, physician groups) regarding the provision of health care services to enrollees. All such contracts shall comply with Section 641.315, Florida Statutes.

B. A copy of the form of any contract made or to be made between the applicant and senior management employment, as well as any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health care services to enrollees. All such contracts shall comply with Section 641.234, Florida Statutes and 641.315, F.S. if applicable.

Section III-5 Grievance Procedure

A statement describing the HMO's grievance procedure that will facilitate the resolution of subscriber grievances. The grievance procedure must include both formal and informal steps for resolving grievances and must be in compliance with all requirements set forth in Rule 4-191.078 (1 - 12), F.A.C., s.641.21(1)(e), & s. 641.22(9), F.S.

Section III-6 **Bankruptcy Proceedings**

Submit evidence of compliance with Section 641.215, Florida Statutes. This documentation should contain:

A. An acknowledgment that a delinquency proceeding pursuant to Part I of Chapter 631 or supervision by the Office pursuant to s. 624.80-624.87, Florida Statutes, constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization, or conservation of a health maintenance organization.

B. A waiver of any right to file or be subject to a bankruptcy proceeding; and

C. An acknowledgment that the commencement of a bankruptcy proceeding either by or against a health maintenance organization shall, by operation of law, terminate the health maintenance organization's certificate of authority and vest in the Office for the use and benefit of the subscribers of the health maintenance organization the title to any deposits of the insurer held by the Office.

SECTION IV - MANAGEMENT

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

Section IV-1 **List of All Officers, Directors and Stockholders**

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

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

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

Section IV-2 **Biographical Statement and Affidavits for Officers, Directors and Stockholders**

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

The requirements for the affiant's social security as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.0721(1) and (8), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 1 of the Biographical affidavit, please include the affiant's name and social security on a separate page and attach it to the Biographical Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.0721(8), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to insure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

Section IV-3 An Authority for Release of Information

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

Section IV-4 Investigative Background Reports

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

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

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

The fingerprint cards along with the fees are due at the time the application is filed. **No cards other than those furnished by the Office will be accepted.** These cards must be completed at a law enforcement or similar type agency and returned to this Office for processing. Instructions for completing the fingerprint cards are included.

SECTION V - FORMS AND RATES

Note: submit three (3) original copies of each referenced form and rate filing.

Section V-1 **Forms**

A. Submit three copies of each policy, master contract, certificate of coverage, member handbook, application, or any other form the applicant proposes to offer the subscriber. This includes any form showing the benefits to which the subscriber is entitled and any form used in the enrollment process. Every form which the HMO will use in connection with its subscriber contracts must be submitted and must be identified by a unique form number located on the lower left corner of the form.

B. Each subscriber contract must state the procedures for offering comprehensive health care services and offering and terminating contracts to subscribers which will not unfairly discriminate on the basis of age, sex, race, handicap, health, or economic status.

Section V-2 **Rates**

A. Submit three copies of the complete schedule of proposed premium rates for each type of contract. The submission for each separate contract should contain an opinion from a qualified independent actuary. The opinion shall:

(1) Certify that the rates are neither inadequate nor excessive nor unfairly discriminatory;
(2) Certify that the rates are appropriate for the classes or risks for which they have been computed;
(3) Present an adequate description of the rating methodology, following consistent and equitable actuarial principles.

B. Furnish a statement from a qualified independent actuary that the HMO is actuarially sound.

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

CHECK LIST
SECTION I - APPLICATION FEES AND FORM

Company Name: _____

Item #		Completion Check List
1.	Application Fees Paid	☐
	(a) Copy of invoice included (Official Form)	☐
	(b) Copy of check included	☐
	(c) Check mailed to address on Invoice	☐
2.	Fingerprint Processing Fees	☐
	(a) Copy of invoice included	☐
	(b) Copy of check included	☐
	(c) Check mailed to address on Invoice	☐
3.	Deposits and Assessments	☐
	(a) Copy of $10,000 check and copy of Invoice	☐
	(b) Copy of $25,000 check and copy of cover letter	☐
4.	Application for Certificate of Authority (Official Form)	☐
	(a) Application form completed	☐
	(b) Sealed by corporation	☐

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

SECTION II - LEGAL

Item #		Completion Check List
1.	Articles of Incorporation	☐
(a)	Original certification by Florida Secretary of State	☐
(b)	Articles with all amendments attached	☐
2.	Certificate of Status from Florida Secretary of State, signed by proper public official (original document)	☐
3.	Corporate bylaws, rules and regulations, and/or Constitution	☐
(a)	Signed and dated by corporate secretary	☐
(b)	Corporate seal affixed	☐
(d)	Board Resolution	☐
4.	Health Care Provider Certificate.....	☐
	Documentation of a Health Care Provider Certificate or proof of a pending application with AHCA	☐
5.	Outside Representative Authorization Letter	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

SECTION III - FINANCIAL AND RELATED INFORMATION

Item #		Completion Check List
1.	Insurance	☐
	(a) Copy of current general liability policy or plan for self-insurance ..... and Current medical malpractice policy or plan for self-insurance	☐ ☐
	(b) Evidence of current fidelity bond	☐
	(c) Reinsurance treaty	☐
2.	Financial Statements	☐
	(a) Current audited financial statements	☐
	(b) Quarterly financial statement	☐
3.	Plan of Operations	☐
	(Small Employer Carrier Application, if applicable)	☐
	(a) Marketing and Growth	☐
	(1) Description of marketing methods	☐
	(2) A statement describing the applicant, facilities and personnel, etc	☐
	(3) Statement of geographic area to be served	☐

Item #		Completion Check List
(b)	Pro Forma Statements	☐
(1)	Balance sheet	☐
(2)	Income statement	☐
(3)	Cash flow analysis	☐
(4)	Change in financial position	☐
(c)	Statement of Initial Cash	☐
	Provisions for contingencies	☐
(d)	History	☐
(e)	Insolvency Protection Deposit with the Office	☐
(1)	Deposit with the Office	☐
	or	
(2)	Reinsurance Policy	☐
	or	
(3)	Guarantee Arrangement	☐
(f)	Contingency Plans	☐
(g)	Feasibility study	☐
4.	Contracts	☐
(a)	Provider contract form and signature pages	☐
(b)	Other forms of contracts	☐

Item #		Completion Check List
5.	Grievance Procedure	☐
	(a) Formal and informal steps included	☐
6.	Bankruptcy Proceedings	☐
	(a) Acknowledgement filed	☐
	(b) Waiver for bankruptcy proceeding	☐
	(c) Acknowledgement for bankruptcy proceeding	☐

SECTION IV - MANAGEMENT

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

(c) Contains original signature ..... ☐

(d) Notarized (original) ..... ☐

(e) Original of each affidavit submitted ..... ☐

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

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

SECTION V - FORMS AND RATES

Item #		Completion Check List
1.	Forms	☐
	(a) 3 copies of each form	☐
	(b) Identified by unique form number	☐
2.	Rates	☐
	(a) 3 copies of each rate schedule and or contract placed with original application	☐
	(b) Rates are neither inadequate, excessive, nor unfairly discriminatory	☐
	(c) Rates are appropriate for class	☐
	(d) Description of rating methodology	☐
	(e) Statement from a qualified actuary that the HMO is actuarially sound	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

RETURN THE COMPLETED CHECK LIST WITH THE APPLICATION PACKAGE.

Pursuant to Chapter 641, Part I, Florida Statutes, application is hereby submitted to form and operate a Health Maintenance Organization.

Proposed name of Health Maintenance Organization:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

FEDERAL IDENTIFICATION NUMBER: _____

PHONE: _____

SOLVENCY CONTACT PERSON: _____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____

This company, through its duly authorized officers, hereby applies for a certificate of authority authorizing and empowering it to operate as a Health Maintenance Organization in the state of Florida, under the laws thereof, and do hereby swear or affirm that all of the responses, information, exhibits, and documentary evidence submitted in support of this application are true and correct.

Signed this _____ day of _____, 20 ___

_____
President or other authorized officer (please print)

_____
Signature (Corporate Seal)

_____
Second authorized officer (please print)

_____
Signature

State of _____

County of _____

Sworn to and subscribed before me

this _____ day of _____, 20 ___

Notary Public

(Notary Seal)

My Commission Expires

Office of Insurance Regulation
Company Admissions

APPLICATION FOR LICENSE
HOME WARRANTY ASSOCIATION

The Office receives applications electronically. Please submit your application at http://www.floir.com/iportal, using the i-Apply 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.

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

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

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR LICENSE
HOME WARRANTY ASSOCIATION

INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORMS

Section 1-1 License Fee

Applicants must pay a license fee of $200. This fee is due and payable at the time of filing the application for licensure.

Secure your check to the INVOICE (included in this package) and send to:

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

Place a copy of the INVOICE and a copy of the check with your application filing. This procedure will expedite the processing of your application and assure a timely recording of the fee.

Section 1-2 Fingerprint Fee

Applicants are required to prepay electronically for the processing of the fingerprint cards required in section IV-5. Please see form OIR-C1-938 for instructions. The fingerprint cards are to be submitted with the application filing.

Place a copy of your on-line payment confirmation along with the fingerprint cards in the management section (IV-5).

NOTE: 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.

NOTE: Individuals who are non-U.S. citizens with no social security number should continue to submit payment of fingerprint fees per instructions in form OIR-C1-903.

Section 1-3 Application for License to Conduct Business in the State of Florida (Home Warranty Association) (Official Form).

Complete this form and have it signed by the President and Secretary of the company. An original signature and corporate seal are required on the application form submitted to the Office.

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR LICENSE
HOME WARRANTY ASSOCIATION

INSTRUCTIONS
SECTION II - LEGAL

Section 11-1 Articles of Incorporation

Include in this section, the applicant's Articles of Incorporation and all amendments. They must be recently certified by the State of domicile. The certification letter must be an original, certified by the State of domiciles public official having custody of the original certificate.

Section 11-2 Certificate of Status from Florida Secretary of State

Provide an original certificate of status from the Florida Secretary of State if the applicant is a foreign corporation. All foreign corporations are required to secure, through the office of the Secretary of State of Florida, a charter to do business in Florida.

If you have any questions concerning filing with the Secretary of State, please contact the Division of Corporations at (850) 245-6051.

The Secretary of State will mail you a Certificate of Status. This original certificate must be forwarded to the Office of Insurance Regulation as part of your application as proof of your filing with the Secretary of State as a foreign corporation.

Section 11-3 Company Bylaws

The Bylaws must be sealed by the company and signed and dated by the Secretary of the company. **NO** signatures other than the Secretary's signature will be accepted.

Section 11-4 Service of Process Consent and Agreement (Official Form)

The Service of Process Consent and Agreement form (attached). **NO** signatures other than those of the President or Chief Executive Officer and the Secretary will be accepted, and the signatures must be under corporate seal.

Section 11-5 Fictitious Name Filing

If the organization plans to utilize a fictitious name, include in this section one certified copy (not a photocopy) of a certificate from the Clerk of the Circuit Court in the county where domiciled, attesting to compliance with Section 865.09, Florida Statutes (the Fictitious Name Statute).

Section 11-6 Certificate of Status from State of Domicile

A certificate of status is a document issued by the public official having supervision of the records of corporations, usually the Secretary of State. This document shows that the company is duly organized in the state and that all taxes and fees have been paid. The certificate must be obtained from the applicant's home state and filed with the application. It must show good standing, be sealed by the state, and be an original document, not a copy.

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR LICENSE
HOME WARRANTY ASSOCIATION

INSTRUCTIONS
SECTION III - FINANCIAL

Section 111-1 Financial Statements

The applicant must submit complete financial statements that contain a balance sheet, income statement, and statement of cash flows. These statements should be certified as true and correct by two officers and may not be more than twelve (12) months old.

Section 111-2 Financial Requirements

The applicant must comply with either of the following:

A. Supply the Office with a copy of an approved executed contractual liability insurance policy. (See the attached sample policy form for approvable language.)

   The insurance company issuing the policy must be a Florida admitted property and casualty insurance company whose Certificate of Authority allows it to write this type of policy. Policies issued by Surplus Lines insurers are **not** acceptable.

   Or,

B. Supply the Office with a sworn statement of the applicant's intentions to establish and maintain a 25% reserve as outlined by Section 634.3077(1), Florida Statutes. If the applicant has home warranties on its books at the time of application, provide a list of the assets funding the reserve.

Section 111-3 Deposit

To assure the faithful performance of its obligations to its contract holders in the event of insolvency, each home warranty association shall, before the issuance of its license, deposit and maintain securities of the type eligible for deposit. a.) Home warranty associations shall deposit $100,000 in securities in accordance with Section 625.52, Florida Statutes. OR, b.) The applicant may file with the Office, subject to the approval by the Office, a surety bond issued by an authorized surety insurer not to exceed an amount of $75,000 plus; a deposit equal to a minimum amount of $25,000 in securities in accordance with Section 625.52, Florida Statutes.

For information on how to make the required securities deposit, contact the Bureau of Collateral Management at:

Department of Financial Services
Bureau of Collateral Management
Capitol Building - Room P-3
Tallahassee, FL 32399-0345
(850) 413-3167

Section 111-4 Plan of Operations

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

A. **History.** Applicant should prepare a brief history of the company since its incorporation. Indicate any changes of ownership or changes in operations. Indicate any actions taken by governmental agencies that have or had jurisdiction over the company.

Also in this section, list all companies or individuals which directly or indirectly control, or are controlled by, or under control of, the applicant. Include the names and addresses of all affiliates, subsidiaries, or related entities. Along with the list, an organizational chart must be included for clarification purposes.

In addition, provide a list of all d/b/a's, trade names, or fictitious names, plan or contract names, or any other name the general public may recognize. Provide any names, trademark, or emblem which is distinctive and not similar to the name or trademark of any other association, corporation, or organization already doing business in this State as will tend to mislead or confuse the public, as required by Section 634.304 (3), Florida Statutes.

B. **Management.** Applicant is to provide its home warranty experience in the areas of marketing, claims handling, accounting and investments.

C. **Products.** Applicant should give a description of each product it plans to market.

D. **Marketing and Growth.** Applicant should furnish a plan of marketing including methods, rates, and commissions, projected growth pattern and other pertinent information affecting marketing plans.

Section 111-5 States Where Applicant is Currently Doing Business

In this section, the applicant should provide a list of states in which it or affiliated companies conduct home warranty business.

Section 111-6 Alphabetical List of Proposed Sales Representatives

The applicant should complete the attached form relating to proposed sales representatives. It is understood that most applicants do not have a complete sales force in place; however, this information should be provided to the best of your ability.

Information on the licensing of sales representatives may be obtained from the Bureau of Licensing by calling (850) 413-3137.

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR LICENSE
HOME WARRANTY ASSOCIATION

INSTRUCTIONS
SECTION IV - MANAGEMENT

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

Section IV-1: List of All Officers, Directors and Shareholders

A. List on the enclosed form, Complete List of Officers, Directors, and Shareholders (10% or more), the names of each officer, director, and person having direct or indirect control of the organization, including officers and directors up through the ultimate parent corporation or holding company. Use a separate form for each company.

Include on this form the names of each shareholder owning ten percent (10%) or more of any class of any outstanding stock of the organization, including shareholders owning ten percent (10%) or more up through the ultimate parent corporation, together with the percentage, number of shares, and class of shares held by each shareholder. If any 10% or greater owner is an entity other than a natural person, please list the owners, officers, directors, and managing members of this entity on the referenced forms. Use a separate form for each company.

B. If the applicant is a subsidiary of a parent or holding company, provide an organization chart showing the relationship of all related corporations.

C. Full names, including middle names, must be listed. Please state if a middle name does not exist.

Section IV-2 Biographical Statement and Affidavit for Officers, Directors and Shareholders

Provide a biographical affidavit (Form OIR-C1-1423) for each officer, director, and shareholder listed in Section IV-1 except for those companies in the organizational structure between the immediate parent and the ultimate parent. All questions must be answered. If, however, the biographical affidavits are currently on file and are not more than two years old, no submission is necessary.

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 page 6 of the NAIC form, please include the affiant's name and social security number on a separate page and attach it to the Biographical Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

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

Section IV-3 Investigative Background Reports

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

Section IV-4 Fingerprint Cards

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

Due to the length of time required by law enforcement agencies to process fingerprint cards, it is suggested that the cards be ordered immediately so they may be submitted before or with the application.

Please place the completed fingerprint cards in this section.

Note: 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 for instructions.

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR LICENSE
HOME WARRANTY ASSOCIATION

INSTRUCTIONS
SECTION V - FORMS AND RATES

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

Section V-1_Forms

Submit three copies of all proposed warranty contracts, related forms and sales brochures. The warranty contracts and applications for warranty contracts should be serially pre-numbered and contain spaces for the selling price; the name of the issuing sales representative; the date of issuance; the contract period; and the name, address and phone number of the contract holder.

Section V-2 Rates

Submit three copies of all rates to be charged, rating schedules or rating manuals. Please note that all warranty contracts must be sold at the approved rates.

Section V-3 Commission Structure

Submit a complete breakdown of your proposed commission structure. This breakdown should include but not be limited to: sales representatives, agents, insurers and licensed administrators.

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR LICENSE
HOME WARRANTY ASSOCIATION

CHECK LIST
SECTION I - APPLICATION FEES AND FORM

Company Name: _____

Item #		Completion Check List
1.	Specialty insurer license fee paid	___
	(a) Copy of invoice included (Official Form)	___
	(b) Copy of check	___
	(c) Copies placed as top documents in application	___
	(d) Original mailed to Bureau of Financial Services	___
2.	Fingerprint fees paid electronically	___
(a)	Copy of on-line payment confirmation	___
	Or, if applicable	
	(b) Copy of form OIR-C1-903 (Invoice) included	___
	(c) Copy of Check included	___
	(d) Originals mailed to Bureau of Financial Services	___
3.	Company completed application for license (Official Form)	___
	(a) All blanks completed	___
	(b) Sealed by company	___
	(c) Signed by President (original signature)	___

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR LICENSE
HOME WARRANTY ASSOCIATION

CHECK LIST
SECTION II - LEGAL

Company Name: _____

Item #		Completion Check List
1.	Articles of Incorporation	___
	(a) Original certification by State of domicile's public custodian	___
	(b) Articles with all amendments attached	___
2.	Certificate of Status from Florida	___
	(a) Good standing indicated	___
	(b) Sealed by State	___
	(c) Signed by Secretary of State	___
	(d) Original.	___
3.	Company Bylaws	___
	(a) Signed and dated by corporate secretary	___
	(b) Sealed by the company (corporate seal)	___

4. Service of Process Consent and Agreement (Official Form) .....___

(a) Signed and dated by:

1. President or Chief Executive Officer .....___

2. Secretary .....___

(b) Sealed by company (corporate seal) .....___

(c) Original with all blanks completed .....___

5. Fictitious Name Certificate (if applicable) .....___

(a) Original .....___

6. Certificate of Status from State of Domicile.....___

(a) Good standing indicated .....___

(b) Sealed by State .....___

(c) Signed by Secretary of State .....___

(d) Original .....___

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR LICENSE
HOME WARRANTY ASSOCIATION

CHECK LIST
SECTION 111 - FINANCIAL

Company Name:_____

Item #			Completion Check List
1.		Financial Statements	___
	(a)	Balance sheet	___
	(b)	Income statement	___
	(c)	Statement of cash flows	___
	(d)	Verified under oath by at least two of the principal officers	___
	(e)	Not over 12 months old	___
	(f)	If indication of a parent corporation in Section IV, financial statement for parent	___
2.		Financial requirements	___
	(a)	A copy of the executed contractual liability insurance policy	___
		Or	
	(b)	A sworn statement of intent to establish a reserve	___
		If applicable, a list of the assets funding the reserve	___
3.	Deposit:		
	(a)	**$100,000**	___
		Or	
	(b)	$25,000 and $75,000 Surety bond	___

4. Plan of Operations .....___

   (a) History .....___

   List of controlling or controlled companies .....___

   List of d/b/a's, trade names, or fictitious names .....___

   (b) Management .....___

   (c) Products .....___

   (d) Marketing & Growth .....___

5. List of states in which the applicant is licensed to operate .....___

6. List of sales representatives (Official Form) .....___

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR LICENSE
HOME WARRANTY ASSOCIATION

CHECK LIST
SECTION IV - MANAGEMENT

Company Name:_____

Item #		Completion Check List
1.	Listing of all officers, directors, controlling individuals and shareholders	___
	a. Separate listing of all officers, directors, controlling individuals, and shareholders including percentage held and number and class of shares for the company and its parents and/or holding companies (Official Form)	___
	b. If parent company indicated, organization chart	___
	c. Full names and titles listed (including full middle name or indication if one does not exist)	___
2.	Biographical Affidavits for each individual listed in Section IV-1 (Official Form)	___
	For each form:	
	(a) All blanks completed	___
	(b) Contains original signature	___
	(c) Notarized (original)	___
	(d) Full name given (including full middle name or indication if one does not exist)	___
	(e) Submitted original of each affidavit	___
	(f) Provide Social Security Number on separate page	___

3. Investigative Background Report for each Individual listed in Section IV-1 .....___

4. Fingerprint cards enclosed for each person listed in Section IV-1 .....___

For each card:

(a) Card obtained from the Office of Insurance Regulation .....___ (b)

Card contains original signature ..... ___ (c)

No erasures on or alteration of card .....____ (d)

All blanks completed .....____

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR LICENSE
HOME WARRANTY ASSOCIATION

CHECK LIST
SECTION V - FORMS AND RATES

Company Name: _____

Item #		Completion Check List
1.	Forms and sales brochures	____
	(a) 3 copies	____
	(b) Serially pre-numbered	____
	(a) Spaces for:	
	(1) Selling price	____
	(2) Name of issuing sales representatives	___ (3)
	Date of issuance	____ (4)
	Contract period	___
	(5) Contract holder's names, address, and phone number	___
2.	Rates to be charged	____
	(a) 3 copies	____
3.	Proposed commission structure	_____

OIR-C1-490
REV 12/05
69O-199.015

FLORIDA OFFICE OF INSURANCE REGULATION

CHECKLIST VERIFICATION

The undersigned says that he/she is a senior officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with licensure sought by _____ that he/she has read said
(Entity Name)
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

OIR-C1-490
REV 12/05
69O-199.015

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION

APPLICATION FOR LICENSE TO CONDUCT BUSINESS
IN THE STATE OF FLORIDA
HOME WARRANTY ASSOCIATION

_____,20__

TO THE DIRECTOR OF INSURANCE REGULATION OF THE STATE OF FLORIDA, TALLAHASSEE, FLORIDA

SIR: The _____
(Give name of applicant company in full)

Federal Identification Number _____

Of_____
(Home Office Address) (City) (State) (Zip)

Telephone: ( )_____Fax: ( )_____

E-Mail Address: _____

through its duly authorized officers, hereby applies for license authorizing and empowering the company aforesaid to transact home warranty business in the State of Florida, under the laws thereof and do hereby affirm that all of the responses, information, exhibits, and documentary evidence submitted in support of this application are true and correct.

By:_____
President or Chief Executive Officer

(Corporate Seal)

Attest_____
Secretary

Name of Attorney or Principal filing this application:

Name:_____Title:_____

Company:_____

Street Address:_____

City:_____State:_____Zip Code:_____

Telephone: ( )_____Fax: ( )_____

E-Mail Address: _____

OIR-C1-490
REV 12/05
69O-199.015

INVOICE

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSRUANCE RETULATION
HOME WARRANTY ASSOCIATION
REQUEST FOR PAYMENT OF APPLICATION FEES

The enclosed check number _____, in the amount of $ _____, dated _____ is transmitted herewith to cover taxes and fees due the State of Florida.

Corporation Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

_____
(Corporate Official)

Forward to: Department of Financial Services
Office of Financial Services
Post Office Box 6100
Revenue Processing Section
Tallahassee, Florida 32314-6100

FOR DEPARTMENT USE ONLY

RECEIPT NUMBER	AMOUNT	TYPE	CLASS	FUND	AMOUNT	SOURCE
	$200.00	10	31			

LICENSE NUMBER	Dated			Mailed			
	MO	DAY	YR	MO	DAY	YR	MAILED BY

FLORIDA OFFICE OF INSURANCE REGULATION PREMIUM GROWTH REPORTING FORM

Due Date:_____Last day of the month following the current month reported

As of_____, 19____

Company Name:_____

NAIC Company Code:_____Date Licensed in Florida:_____

(Round to nearest thousand.)

Columns		1	2	3	4	5	6	7	8	9	10	11	12
Part (1a)	Totals Most Recent 12 Months	Current Year Most Recent Month	1 Month Prior	2 Months Prior	3 Months Prior	4 Months Prior	5 Months Prior	6 Months Prior	7 Months Prior	8 Months Prior	9 Months Prior	10 Months Prior	11 Months Prior
* Direct													
* Assumed													
* Total (1a)													

Part (1b)	Totals Previous 12 Months	12 Months Prior	13 Months Prior	14 Months Prior	15 Months Prior	16 Months Prior	17 Months Prior	18 Months Prior	19 Months Prior	20 Months Prior	21 Months Prior	22 Months Prior	23 Months Prior
	<----------	----------	----------	----------	--Previous 12 months---		----------	----------	----------	----------	----------	----------	---------->
* Direct													
* Assumed													
* Total (1b)													

** Part (1c)

Subtract
(1a) - (1b) = _____

** Part (1d)

Divide
(1c)/(1b) = _____

I_____, of_____, an insurer licensed to transact insurance in the state of Florida, do hereby certify under penalty of perjury pursuant to 837.06 F.S. that the information reported above is a full and true report of the direct and assumed premiums written from the United States and its territories. This report is submitted for compliance with Section 624.4243, Florida Statutes.

_____ _____
Signature Date

_____
Type Name and Title

* Sum Columns 1 - 12
** Do not complete these parts until 24 operating months have been reported.

OIR-A1-1229
Revised 9/06
Rule 69O-137.003

Department of Financial Services
Division of Administration – Bureau of Financial Services

STATE OF FLORIDA
VOUCHER FOR REIMBURSEMENT OF TRAVEL EXPENSES

TRAVELER:
SOCIAL SECURITY # Non-Employee ( )
ORG CODE: EO:

DEPARTMENT OF FINANCIAL SERVICES
HEADQUARTERS
RESIDENCE (CITY)
Prepared by: Phone#

Date	Travel Performed From Point of Origin To Destination	Purpose or Reason (Name of Conference)	Hour of Departure and Hour of Return	Meals for Class A & B Travel	Actual Lodging Expenses	Per Diem	Map Mileage Claimed	Vicinity Mileage Claimed	Other Expenses/Common Carrier Paid by Traveler	
									Amount	Type
4/12/2008										

TRAVEL PERFORMED BY COMMON CARRIER OR STATE VEHICLE *THIS SECTION REQUIRED TO BE COMPLETED ONLY WHEN COMMON CARRIER IS BILLED DIRECTLY TO THE STATE AGENCY.*					
DATE	TICKET NUMBER OR STATE VEHICLE NUMBER	FROM	TO	AMOUNT	NAME OF COMMON CARRIER OR STATE AGENCY OWNING VEHICLE

STATE OF FLORIDA PURCHASING CARD CHARGES THIS SECTION REQUIRED TO BE COMPLETED ONLY WHEN TRAVEL RELATED EXPENSES ARE PAID BY USING THE STATE OF FLORIDA PURCHASING CARD			
DATE	MERCHANT/VENDOR	DESCRIPTION OF ITEM ACQUIRED	AMOUNT OF CHARGE

THIS SECTION REQUIRED TO BE COMPLETED ONLY WHEN NON-REIMBURSABLE ITEMS WERE PURCHASED USING THE STATE OF FLORIDA PURCHASING CARD			
DATE	MERCHANT/VENDOR	DESCRIPTION OF ITEM ACQUIRED	AMOUNT OF CHARGE
(THIS AMOUNT MUST APPEAR ON LINE "LESS NON-REIMBURSABLE ITEMS INCLUDED ON PURCHASING CARD" ON REVERSE SIDE OF THIS FORM) TOTAL			0

GENERAL INSTRUCTIONS

Class A travel – Continuous travel of 24 hours or more away from official headquarters
Class B travel – Continuous travel of less than 24 hrs which involves overnight absences from official headquarters.

Breakfast --- when travel begins before 6 a.m. and extends beyond 8 a.m.
Lunch ------- when travel begins before 12 Noon and extends beyond 2 p.m.
Dinner ------ when travel begins before 6 p.m. and extends beyond 8 p.m. or when travel occurs during night-time hours due to special assignment.

NOTE: No allowance shall be made for meals when travel is confined to the city or town of official headquarters or immediate vicinity except assignments of official business outside the traveler's regular place of employment if travel expenses are approved and such special approval is noted on the travel voucher. Rate of Per Diem and Meals shall be those prescribed by Section 112.061, Florida Statutes.

Non-reimbursable items may not be charged on the State of Florida Purchasing Card. Inadvertent non-reimbursable charges are to be deducted from the travel reimbursement claimed on the reverse side of this form on the line "Less Non-reimbursable Items Included on Purchasing Card" and the above "Non-reimbursable Items" section of "State of Florida Purchasing Card Charges" section above must be completed. Per diem shall be computed at one-fourth of authorized rate for each quarter or fraction thereof. Class A travel will be calculated on the basis of 6-hour cycles, beginning at midnight; Class B travel will be calculated on the basis of 6-hour cycles, beginning at the hour of departure from official headquarters. Hour of departure and hour of return should be shown for all travel. When claiming per diem, the meal allowance columns should not be used. Claims for actual lodging at single occupancy rate should be put in the "Per Diem or Actual Lodging Expense" column and include the appropriate meal allowances in the "Meals for Class A & B Travel" column. Vicinity travel mileage must appear in the separate column. When travel is by common carrier and billed directly to the traveler, the amount and description should be included in the "Other Expenses" column. A copy of the ticket or invoice should be attached to this form. If travel is by common carrier and billed directly to the State agency, then the "Travel Performed by Common Carrier or State Vehicle" section above should be completed. If travel is by common carrier and the carrier is paid by the use of the State of Florida Purchasing Card, then the "State of Florida Purchasing Card Charges" section above should be completed. The name of the common carrier should be inserted in the "Map Mileage Claimed" column in these instances. Justification must be provided for use of a non-contract airline (or one offering equal or lesser rates than the contract airline) or rental car (or one having lower net rate) when contract carriers are available. Justification must be provided for use of a rental car larger than a Class "B" car. If travel is performed by the use of a State-owned vehicle, the word "State" should be inserted in the "Map Mileage Claimed" column on the reverse side of this form, and the above section designated as "Travel Performed by Common Carrier or State Vehicle" should be completed. If lodging is paid by the use of the State of Florida Purchasing Card, the words "Purchasing Card" should be inserted in the "Per Diem or Actual Lodging Expenses" column on the reverse side of this form, and the above section designated as "State of Florida Purchasing Card Charges" should be completed. Incidental travel expenses which may be reimbursed include: (a) reasonable taxi fare; (b) ferry fares and bridge, road and tunnel tolls; (c) storage and parking fees; (d) telephone and telegraph expenses (e) convention or conference registration fee. If meals are included in the registration fee, per diem should be reduced accordingly. Receipts should be obtained when required. The official Department of Transportation map should be used in computing mileage from point of origin to destination whenever possible. When any State employee is stationed in any city or town for over 30 continuous work days, such city or town shall be deemed to be his official headquarters and he shall not be allowed per diem or subsistence after the period of 30 continuous work days has elapsed, unless extended by the approval of the agency head.

DFS-C1-500 Rev 12/13 69O-138.005

Office of Insurance Regulation
Property and Casualty Financial Oversight

FLORIDA COMPANY CODE:

_____

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

_____

ANNUAL REPORT OF THE

_____

(Home Warranty Association)

TO THE
OFFICE OF INSURANCE REGULATION
OF THE
STATE OF FLORIDA

Property and Casualty Financial
Oversight
200 East Gaines Street
Tallahassee, FL 32399-0329

FOR CALENDAR YEAR ENDED

_____

DUE ON OR BEFORE
MARCH 1 EACH YEAR

Company Name: Year Ending:

GENERAL INFORMATION AND INSTRUCTIONS

1. Financial statements must be prepared in accordance with generally accepted accounting principles and as prescribed in the Florida Statutes.

2. The Balance Sheet, Statement of Operations and the Statement of Cash flows must be prepared based on year-end amounts.

3. All terms used in this report will have their general meaning except where specific statutory language applies under the applicable provisions of the Florida Insurance Code.

4. This form is submitted electronically. Adobe Reader version 7.0.5 or higher is required. If you do not have that version, please upgrade at http://www.adobe.com prior to downloading any forms.

5. When you downloaded this report, you were assigned a session key. This session key has an expiration date that was also assigned prior to downloading this form. **Please make sure you save or submit prior to this expiration date or all work up until the last save will be lost.**

   This session will expire on: Eastern Time

6. To assist you in completing this form click both "Highlight Fields" and "Highlight Required Fields" in the upper right hand corner of the report page. This will highlight the fields where you may enter data.

7. The report form will calculate all totals and pre-populate fields based upon your responses. Data cannot be entered into the total and pre-populated fields.

8. Please enter all numeric fields with numbers only (no commas, dashes, dollar signs, etc.). Unanswered questions and blank lines on schedules will not be accepted. If no answers or entries are to be made, enter "0" on all lines asking for a numeric response and "None" or "N/A" on all lines requesting a non-numeric response. Additionally, certain Schedules and Exhibits provide the option "Check if N/A" if the information requested is not applicable to your company.

9. Line descriptions may not be altered or added. When in doubt where to place an item, show the item in an appropriate "Other" line and include a supplemental schedule describing the items listed in the "Other" category. Any item which is of an extraordinary nature should also be entered on an appropriate "Other" line.

10. "Save" or "Submit" buttons are provided on the last page of this report. Hit the ALT+s keys to go to the last page. By clicking the Save button, all data entered on the form will be saved to our website. **It is strongly recommended that you save your data periodically as you fill in this form.** You will receive a confirmation message once the data is successfully saved.

11. When you either save or submit the form, all data is checked for completeness; you will be notified if errors have occurred. When submitting data, you will be asked to correct these validation errors. Once the form is successfully submitted, the form becomes read-only. **To update information after submission, an amended form must be filed through REFS.**

12. If additional explanations, supporting statements or schedules are added or are necessary, the additions should be properly cross-referenced to the item being answered. This additional information should be in electronic format (i.e. Word, Excel, PDF, etc) or, if in paper format, scanned in as a PDF, and should be attached and uploaded to the filing as a Miscellaneous Document through REFS.

13 When you have completed a form and selected "Submit Final," your report form is uploaded as a "Completed" document to your Component List; this does not submit the report to the Office of Insurance Regulation. Upon completion of all required items, the "Begin Submission Process" button (bottom right of the screen) will activate. You must select and complete the "Begin Submission Process" to successfully submit your entire filing to OIR.

14. Please print, sign, notarize and upload a PDF version of the Jurat/Attestation Page (see next page) under the corresponding component in REFS. If you do not have a component so named, please upload a signed PDF under the Miscellaneous Documents component.

Company Name: Year Ending:

STATEMENT

Please see the Instructions Page OR you may notarize this form electronically by entering the Notary Public, Commission Number and Expiration Date on the form prior to submitting.

Company Name: _____

Company FEIN: _____ Florida Company Code: _____ Period Ending Date: _____

State and Date of Incorporation/Organization: (State/Prov): _____ (Date): _____

Date Licensed by the Office of Insurance Regulation: (Date): _____

Date Commenced Business: (Date): _____

Address of Home Office:

Street: _____

City: _____ State/Prov: _____ Zip/Postal Code: _____

Phone: _____ Ext: _____ Fax: _____

Address of Main Administrative Office:

Street: _____

City: _____ State/Prov: _____ Zip/Postal Code: _____

Phone: _____ Ext: _____ Fax: _____

Mailing Address:

Street: _____

City: _____ State/Prov: _____ Zip/Postal Code: _____

Phone: _____ Ext: _____ Fax: _____

Records Location (if different than Main Office):

Street: _____

City: _____ State/Prov: _____ Zip/Postal Code: _____

Address of Principle Florida Office:

Street: _____

City: _____ State/Prov: _____ Zip/Postal Code: _____

Phone: _____ Ext: _____ Fax: _____

Website: _____

Type of entity (check one)

- ☐ Corporation - For profit
- ☐ Corporation - Not for profit
- ☐ Partnership
- ☐ Sole proprietorship
- ☐ Limited liability company
- ☐ Other: _____

Contact Name: _____

Contact Title: _____

Phone: _____ Ext: _____ Fax: _____

Email Address: _____

OFFICERS / DIRECTORS / MEMBERS

Show full name (initials not acceptable)

Expiration Date: _____

Print this page

Company Name: Year Ending:

BALANCE SHEET
ASSETS

		December 31	
CURRENT ASSETS:		**Current Year**	**Last Year**
1.	Cash on Hand and on Deposit (Schedule A - Page 7)		
2.	Investments (Schedule B - Page 8)		
3.	Receivables (Schedule C - Page 9)		
	Allowance for Doubtful Accounts	( )	( )
4.	Prepaid Expenses		
5.	Inventories		
6.	Other Current Assets (Schedule D - Page 10)		
7.	**Total Current Assets**		
NON-CURRENT ASSETS:			
8.	Investments (Schedule B - Page 8)		
9.	Receivables (Schedule C - Page 9)		
	Allowance for Doubtful Accounts	( )	( )
10.	Deferred Acquisition Expenses (Attach Details)		
11.	Deferred Expenses		
12.	Intangible Assets		
13.	Other Non-Current Assets (Schedule D - Page 10)		
14.	**Total Non-Current Assets**		
FIXED ASSETS (NET OF ACCUMULATED DEPRECIATION)			
15.	Real Estate Owned		
16.	Automobiles		
17.	Office Equipment & Furniture		
18.	Leasehold Improvements		
19.	Other Fixed Assets (Schedule D - Page 10)		
20.	**Total Fixed Assets (Net of Accumulated Depreciation)**		
21.	**Total Assets**		
22.	Less Non-Admitted Assets (Schedule E, Line 10, Page 11)	( )	( )
23.	**TOTAL ADMITTED ASSETS**		

Company Name: Year Ending:

BALANCE SHEET
LIABILITIES AND STOCKHOLDERS' EQUITY

		December 31	
LIABILITIES:		**Current Year**	**Last Year**
1.	Accounts Payable		
2.	Commissions Payable		
3.	Taxes Payable		
4.	Current Portion of Notes Payable (Schedule F - Page 12)		
5.	Accrued Interest Payable		
6.	Claims Payable / Reserve		
	a. Motor Vehicle Warranty (F.S. 634, Part I)		
	b. Home Warranty (F.S. 634, Part II)		
	c. Service Warranty (F.S. 634, Part III)		
7.	Other Current Liabilities (Schedule G - Page 14)		
8.	**Total Current Liabilities**		
9.	Reserve for Unearned Premium		
	a. Motor Vehicle Warranty (F.S. 634, Part I)		
	b. Home Warranty (F.S. 634, Part II)		
	c. Service Warranty (F.S. 634, Part III)		
10.	Long Term Portion of Notes Payable (Schedule F - Page 12)		
11.	Other Long Term Liabilities (Schedule G - Page 13)		
12.	**Total Long Term Liabilities**		
13.	**Total Liabilities**		
STOCKHOLDERS' EQUITY:			
14.	Common Stock		
15.	Preferred Stock		
16.	Additional Paid-in Capital		
17.	Retained Earnings (Line 17 - Page 6)		
18.	Less Treasury Stock	( )	( )
19.	Other (Attach Detail)		
20.	**Total Stockholders' Equity**		
21.	**TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY**		
22.	Total Stockholders' Equity (Line 20 above)		
23.	Less Non-Admitted Assets (Schedule E, Line 10, Page 11)	( )	( )
24.	Statutory Net Worth		

Company Name: Year Ending:

STATEMENT OF OPERATIONS AND RETAINED EARNINGS

		December 31	
INCOME:		**Current Year**	**Last Year**
1.	Premiums Earned		
a.	Motor Vehicle Warranty (F.S. 634, Part I)		
b.	Home Warranty (F.S. 634, Part II)		
c.	Service Warranty (F.S. 634, Part III)		
2.	Total Net Investment Income Earned:		
a.	Net Income Earned on all Reserves		
b.	Net Income Earned on Other Investments		
3.	Net Realized Capital Gains (or Losses)		
4.	Other Income (Attach Schedule)		
5.	**Total Income**		
EXPENSES:			
6.	Claims		
a.	Motor Vehicle Warranty (F.S. 634, Part I)		
b.	Home Warranty (F.S. 634, Part II)		
c.	Service Warranty (F.S. 634, Part III)		
7.	Commissions to Agents		
8.	General Expenses (Attach Schedule)		
9.	**Total Expenses**		
10.	Net Gain (or Loss) from operations before Federal and State Income Taxes and Extraordinary Item(s)		
11.	Extraordinary Item(s) (Attach Schedule)		
12.	Federal and State Income Taxes		
13.	**Net Gain (or Loss) from Operations**		
14.	Retained Earnings, December 31, Previous Year		
15.	Other (Attach Details)		
16.	Less Dividends to Stockholders	( )	( )
17.	**RETAINED EARNINGS** (Enter on Line 17, Page 5)		

Company Name: Year Ending:

SCHEDULE A
CASH ON HAND AND ON DEPOSIT

Check if Not Applicable ☐

Place a check in the column marked with an asterisk (*) to designate if all or any part of the deposit balance is assigned as collateral for a loan or is otherwise restricted. Attach a supporting statement marked Exhibit A-1, describing the nature of the restriction.

Name of Depository (List All Accounts Even If Closed During Period)	*	Balance as of
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	Total Cash On Deposit:	
	Cash On Hand (Petty Cash):	
	TOTAL (Line 1, Page 4):	

Totals of Depository Balances (Demand and Time) as of the Last Day of Each Month During the Current Year

Month	Balance	Month	Balance	Month	Balance	Month	Balance
JAN		APR		JUL		OCT	
FEB		MAY		AUG		NOV	
MAR		JUN		SEP		DEC	

Company Name: Year Ending:

SCHEDULE B
INVESTMENTS

Place a check in the column marked with an asterisk (*) if this investment represents reserve funds invested. Show all stocks, bonds, debenture bonds, collateral or mortgage notes owned and list in the order of their maturity. If stocks and bonds are not traded on one of the major exchanges or over-the-counter, then sufficient information should be given so that the investments may be verified. Collateral and mortgage notes owned should also reflect sufficient data for confirmation. If investment is on deposit with the Department, indicate with a check in the column marked with a number sign (#).

Description	Maturity Date or Number of Shares	*	#	Market Value	Original Cost
Current:					Check if Not Applicable
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
	Total Current (Line 2, Page 4):				
Non-Current:					Check if Not Applicable
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
	Total Non-Current (Line 8, Page 4):				
	TOTAL INVESTMENTS:				

Company Name: Year Ending:

SCHEDULE C
RECEIVABLES

Place a check in the column marked with an asterisk (*) on all receivables which are past due over 90 days.
Under **Description / Name of Debtor**, identify if the Debtor is an **A**ffiliate, **D**irector, **O**fficer, **S**hare **H**older, or **E**mployee / **S**alesperson.

Description / Name of Debtor	*	Security / Nature of Debt	Balance
Current:			Check if **Not** Applicable
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
		Total Current (Line 3, Page 4):	
Non-Current:			Check if **Not** Applicable
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		
		Total Non-Current (Line 9, Page 4):	
		TOTAL RECEIVABLES:	

Company Name: Year Ending:

SCHEDULE D
OTHER ASSETS
(Net of Accumulated Depreciation)

Identify as current, non-current, or fixed where appropriate. Place a check in the column marked with an asterisk (*) if all or any part of the asset is assigned as collateral for a loan or is otherwise restriced.

Name	Nature of Asset	*	Balance
Other Current Assets:		Check if Not Applicable	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
	Total Other Current Assets (Line 6, Page 4) :		
Non-Current Assets:		Check if Not Applicable	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
	Total Other Non-Current Assets (Line 13, Page 4):		
Other Fixed Assets:		Check if Not Applicable	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
	Total Other Fixed Assets (Line 19, Page 4):		
	TOTAL OTHER ASSETS:		

Company Name: Year Ending:

SCHEDULE E
NON-ADMITTED ASSETS

1.	Notes, Accounts Receivables or Advances:		
	a. From Affiliates		
	b. From Controlling Stockholder / Ownership Interest		
	c. From Directors / Officers		
	d. From Employees / Salesmen		
	e. From Others		
	Total (Line 1, entries a through e):		
2.	Fixed Assets costing less than $200 each or amortized longer than five years		
3.	Leasehold Improvements in excess of Statute authorization		
4.	Investments:		
	a. In Subsidiaries		
	b. In Affiliates of Parent / Ultimate Parent		
	Total (Line 4, entries a and b):		
5.	Prepaid Expenses in excess of Liquidation Value		
6.	Deferred Expenses		
7.	Intangible Assets:		
	a. Goodwill		
	b. Franchises		
	c. Customer Lists		
	d. Patents or Trademarks		
	e. Agreements not to Compete		
	f. Others (Identify)		
	Total (Line 7, entries a through f):		
8.	Any Other asset pledged as collateral or otherwise restricted		
9.	Other Assets not allowed by Statute (Identify)		
	Total (Line 9, all entries):		
10.	**TOTAL NON-ADMITTED ASSETS** (Line 22, Column 1, Page 4 and Line 23, Page 5)		

Company Name: Year Ending:

SCHEDULE F
NOTES PAYABLE

Place a check in the column marked with an asterisk (*) to designate Notes due to Affiliates, Directors, Officers, or Controlling Shareholder / Interest.

Description		Balance
Current Portion of Notes Payable: ☐ Check if Not Applicable	*	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
Total Current Portion of Notes Payable (Line 4, Page 5):		
Long-Term Portion of Notes Payable: ☐ Check if Not Applicable	*	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
Total Long-Term Portion of Notes Payable (Line 10, Page 5):		
TOTAL NOTES PAYABLE:		

Company Name: Year Ending:

SCHEDULE G
OTHER LIABILITIES

Name	Nature of Liability	Balance
Other Current Liabilities:	Check if Not Applicable	
	Total Other Current Liabilities (Line 7, Page 5):	
Other Long-Term Liabilities:	Check if Not Applicable	
	Total Other Long-Term Liabilities (Line 11, Page 5):	
	TOTAL OTHER LIABILITIES:	

Company Name: Year Ending:

SCHEDULE H
FUNDED UNEARNED PREMIUM RESERVE
Chapter 634, Florida Statutes

List all assets used to meet the Unearned Premium Reserve requirement(s) for any warranty license(s) held by the Licensee. The reserve is required to be funded with unencumbered assets. The assets shall be held as prescribed under Chapter 625.301 - 625.340, Florida Statutes. (Attach additional pages, if needed.) Please identify any assets on deposit with the Department of Financial Services, Division of Treasury, Bureau of Collateral Management with check in the column marked with an asterisk (*).

Description of Asset	Maturity or Number of Shares	*	Market Value	Original Cost
Motor Vehicle Service Agreement Company				Check if Not Applicable
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
MOTOR VEHICLE SERVICE AGREEMENT COMPANY RESERVES:				
Home Warranty Association				Check if Not Applicable
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
HOME WARRANTY ASSOCIATION RESERVES:				
Service Warranty Association				Check if Not Applicable
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
SERVICE WARRANTY ASSOCIATION RESERVES:				
	TOTAL RESERVES:			

Company Name: Year Ending:

EXHIBIT I
Premiums Written and Premiums Earned

1. Premiums Written, Current Year	
2. Other Fees and Charges	
3. Unearned Premiums at End of Prior Year	
4. Unearned Premiums at End of Current Year	( )
5. Other (Explain)	
6. Premium Earned (Sum of Lines 1 through 5)	*

* Must agree with Line 1b, Column 1, Page 6

EXHIBIT II
Premium to Asset Ratio

1.	Premiums in Force at End of Current Year (From Exhibit IV, Line 5, Column b, Page 17)	
2.	Total Net Assets (From STATUTORY NET WORTH, Line 24, Page 6)	
3.	**Minimum Net Assets Required = Premiums in Force / 6 (Line 2 must be greater than or equal to Line 1 divided by 6)**	
4.	If Line 2 is Less than Line 3, the difference must be infused to correct the net worth deficiency:	

EXHIBIT III
Claims

	(a) Number of Contracts	(b) Amount of Claims	(c) Average Amount of Claims**
1. Claims Paid for Current Year			
2. Claims Reported but Not Paid for Current Year			
3. Claims Incurred but Not Reported			
4. Total Current Year Claims Expense (* Must agree with Line 6b, Column 1, Page 6)		*	
5. Claims Paid for the Prior Year			
6. Claims Incurred But Not Reported, for the Prior Year			
7. Other (Explain)			

** Column (c) = Column (b) / Column (a)

Company Name: Year Ending:

EXHIBIT IV
Summary of Business Written in All States, Including FLORIDA
(Accrual Basis)

	(a) Number of Contracts	(b) Premium Amount	(c) Statutory Reserves
1. In-Force at End of Prior Year			
2. Issued During Current Year			
3. Cancellations & Refunds During Current Year	( )	( )	
4. Expirations During Current Year	( )	( )	
5. In-Force at End of Current Year			*

Columns (a) & (b): 1+2-3-4=5; Column (c) must be at least 25% of Column (b)
* Must agree with Line 9b, Page 5

EXHIBIT V
Summary of Business Written - FLORIDA Only
(Accrual Basis)

	(a) Number of Contracts	(b) Premium Amount	(c) Statutory Reserves
1. In-Force at End of Prior Year			
2. Issued During Current Year			
3. Cancellations & Refunds During Current Year	( )	( )	
4. Expirations During Current Year	( )	( )	
5. In-Force at End of Current Year			

EXHIBIT VI
Summary of Premiums & Assessments Received - FLORIDA Only
(Cash Basis)

	Amount Collected
1. Home Warranty Premiums Collected During Current Year	
2. Home Warranty Assessments Collected During Current Year	
3. Home Warranty Fees Collected During Current Year	
4. Cancellations & Refunds During Current Year	
5. Net Collections at End of Current Year **(Enter on OIR-A3-440)**	
6. Premium Tax Due (2% of Line 5) **(Enter on OIR-A3-440)**	**0**

Include as part of "Taxes Payable", Line 3, Page 5)

ECTORS AND KEY PERSONNEL

dministrators. Include shareholders and affiliates holding at least 10% interest in the operations of the provider. inated, designated or has been added to this list during this report period, place a check in the "New" column lease refer to the instructions provided at http://www.floir.com/siteDocuments/OfficeDirector.pdf.

Address	City	State/ Prov.	Zip/Postal Code	Date of Birth	%	New
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Click Alt+s to jump to the Save/Submit page

OF COMPANIES

; of the provider. State the percentage owned. If such company has been added to this list during this report

Address	City	State/ Prov.	Zip/Postal Code	FEIN	%	New
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Click Alt+s to jump to the Save/Submit page

Company Name: Year Ending:

SAVE/SUBMIT PAGE

Save - Use this button to save your data to our server. **It is strongly recommended that you save your data periodically as you fill in this form.** You can still save your data even if you have validation errors appear below.

Submit Final - Use this button if you have entered all the required information and want to submit this data to our server. If you have validation errors, they must be corrected before being able to submit the form data. **Once you successfully submit the form data, you can no longer make changes.**

The session key will expire on: Eastern Time

Save Submit Final

APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORM

Section I-1 Application Fees

Applicants must pay a filing fee of $1,500.00, pursuant to Section 624.501(1)(a), Florida Statutes. The fee is due and payable at the time of filing the application for licensure.

Secure your check to the INVOICE (included in this package) and mail to:

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

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

Section I-2 Application for Certificate of Authority (Official Form)

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

SECTION II - LEGAL

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

Include in this section, the applicant's Articles of Incorporation and all amendments, if applicable. They must be certified by the applicant's state of domicile, by the public official with whom the originals are on file in the state of domicile. The certification must be an original and obtained from that office no earlier than six months prior to the date the application is filed. SUBMIT AN ORIGINAL AND ONE COPY.

Section II-2 **Certificate of Status from Florida Secretary of State of Sponsoring Association**

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

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

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

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

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

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

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

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

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

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

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

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

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

This certificate must be obtained from the Florida Secretary of State's office no earlier than six months prior to the date the application is filed. SUBMIT AN ORIGINAL AND ONE COPY OF THIS DOCUMENT.

APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 **Financial Requirement**

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

Section III-2 **Plan of Operations**

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

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

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

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

C. **Administration.** Applicant should give the name of the service company or third party administrator responsible for servicing the program of the arrangement and should attach a copy of the company's Florida license. In addition, attach a copy of the agreement between the service company or administrator and the trust. This agreement should be signed by the administrator and trustee.

D. **Claims Adjusting and Underwriting.** Applicant should indicate that the arrangement has provided a sufficient number of competent persons to service its program in the areas of claims adjusting and underwriting. Applicant should also describe the present or proposed plan to service billings, claims, and underwriting. The criteria for underwriting should be

justified, and a description of procedures for a special health test pursuant to Section 627.429(4), Florida Statutes, should be included.

E. **Marketing and Growth.** Applicant should provide an outline and description of the management's marketing efforts. Applicant should also list, in this section, the names of all persons directly employed by the arrangement, who solicit participants or adjust claims, indicating whether such person has a license issued by the Office of Insurance Regulation and if so, what type of license. For individuals without licenses, applicant should provide their qualifications.

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

Section III-3 **Fidelity Bond**

In this section, the applicant should provide a copy of the fidelity bond issued in the name of the arrangement covering its trustees, directors, officers, employees, administrator, or other individuals managing or handling the funds or assets of the arrangement. The bond should be in an amount no less than 10% of funds handled annually, but in no case should it be less than $50,000 or more than $500,000.

Section III-4 **Excess Insurance Agreement**

Submit a copy of the present or proposed excess insurance agreement/policy, which should provide that the net retention level for any one risk not exceed $50,000. Along with it, submit a summary description of the agreement with enough detail to indicate the nature of the coverage.

Section III-5 **Fund Balance**

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

Section III-6 **Feasibility Study**

Each applicant must submit a comprehensive feasibility study, performed by a certified public accountant in conjunction with a certified actuary (see Section V-4). The study should include a financial analysis, as well as enrollment assumptions and competitor

information. The study should be for the greater of three years or until the arrangement has been projected to be profitable for twelve consecutive months. The study should show that the arrangement would have and maintain a fund balance as required by Section 624.4392, Florida Statutes and would not, at the end of any month of the projection period, have less than the required balance per Section 624.4392, Florida Statutes. The feasibility study should contain an opinion by the CPA performing the study

which must opine as to the reasonableness of the assumptions used in the feasibility study and that the assumptions are reasonably applied.

The financial portion of the feasibility study must be prepared in accordance with standards promulgated by the American Institute of Certified Public Accountants in its "Guide For Prospective Financial Statements" and opined accordingly and must contain nothing less than an "examination opinion". Outlined below are the requirements for the feasibility study:

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

B. A current audited financial statement prescribed by Section 624.439(11) must be submitted for the proposed arrangement. The audited statement must be certified by an independent certified public accountant. If your group is already operating, submit an annual income statement developed on a statutory accounting principle basis for the past five years.

   NOTE: The current financial statement should include a balance sheet. If the organization is already in business, it should also include an income statement, as well as a statement of changes in financial position. Each arrangement must demonstrate that it will have adequate funding to continually meet the minimum fund balance requirements of Section 624.4392, Florida Statutes. Surplus notes may be used in the calculation of surplus.

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

D. A projected cash flow analysis on a monthly basis, with an annual total through break even for a minimum of three years. Line by line documentation must be submitted. The surplus/ deficit must be the amount used on the cash and cash reserves summary to reflect operations cash flow.

E. A projected balance sheet annually through break even. The balance sheet should be for a minimum of three years and should be developed on a statutory accounting principle basis. It should be accompanied by statements of changes in financial position for the same time period.

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

G. The method in which the Multiple Employer Welfare Arrangement will comply with the insolvency protection deposit requirements of Section 624.441, F.S., including all relevant documentation necessary to meet the requirements. The deposit amount should be the greater of 5% of gross annual premiums for the succeeding year, or 25% of claims expenditures for the previous twelve months.

APPLICATION FOR CERTIFICATE OF AUTHORITY MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

SECTION IV - MANAGEMENT

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

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

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

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

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

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

The requirements for the affiant's social security as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.0721(1) and (8), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a),
Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 1 of the Biographical affidavit, please include the affiant's name and social security on a separate page and attach it to the Biographical

Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.0721(8), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to insure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

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

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

Section IV-4 **Investigative Background Reports**

An investigative background report must be provided for each person listed in Section IV-1. These reports must be mailed directly to the Office of Insurance Regulation from a background investigative agency. As the reports are to be paid for by the applicant, please arrange for the billing to be sent by the investigative reporting firm to your accounting office. See the enclosed form, Instructions For Furnishing Background Investigative Reports, in this package for ordering these reports.

Evidence indicating that these reports have been ordered for all officers, directors, and trustees must be submitted by the applicant. Acceptable evidence includes a copy of the cancelled check issued to the investigative firm in payment for the reports and a copy of the letter of transmittal to the investigative firm with proof of mailing. The evidence should be dated no less than four (4) weeks prior to the date of the application.

SECTION V - FORMS AND RATES

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

Section V-1 Forms

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

> "The benefits and coverages described herein are provided through a trust fund established and funded by a group of employers. It is not an insurance company and is not protected by a guaranty fund in the event of insolvency. Participating employers are assessable for any losses incurred by the trust."

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

Section V-2 Marketing Material

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

Section V-3 Rates

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

Section V-4 Actuarial Rate Analysis

In this section, the applicant should submit a report prepared by a certified actuary, who is a member of the Society of Actuaries or the American Academy of Actuaries. The report should provide evidence that the arrangement will be operated in accordance with sound actuarial principles and that proposed rates will provide sufficient revenues to pay current and future liabilities. The actuarial justification of rates should be prepared in accordance with standards promulgated by the American Academy of Actuaries and opined accordingly.

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

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

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

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

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

Office of Insurance Regulation
Company Admissions

APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID HEALTH CLINIC

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.

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

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

APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID HEALTH CLINIC

Statutory Authority

S. 641.405(1)

Pursuant to Chapter 641, Part III, Florida Statutes, application is hereby made to operate a Prepaid Health Clinic.

Proposed name of Prepaid Health Clinic:

Name: _____

Address: _____

Phone: _____

FEIN: _____

How long has the PHC been in operation:
(Specify beginning date): _____

Please be specific in your answers and provide supporting documentation for each item. The items are as follows:

ORGANIZATIONAL

	Statutory Authority	
____ 1.	S. 641.405(2)(f)	Enclose a copy of the Health Care Provider Certificate, as issued by the Agency for Health Care Administration or evidence that application has been made for a Health Care Provider Certificate.
____ 2.	S. 641.412(1)(a)	A check for $150 made payable to "Department of Financial Services" covering the filing fee for this application.
____ 3.	S. 641.405(2)(a)	A copy of the PHC's basic organizational documents including Articles of Incorporation, Articles of Association, Partnership Agreement(s), Trust Agreement, or other applicable documents and all amendments thereto.
____ 4.	S. 641.405(2)(a)	If the proposed PHC is already incorporated, a copy of the Certificate of Incorporation as filed with the Secretary of State.
____ 5.	S. 641.405(2)(b)	A copy of the proposed PHC's Bylaws, Rules or Regulations, or similar form of document.
____ 6.	S. 641405(2)(c)	A list of names, addresses, and official capacities of all persons who are to be responsible for the conduct of the PHC's affairs including officers and directors, trustees, partners, and associates.
____ 7.	S. 641.406(7)	A list of the owners of the PHC, including the number of shares of stock or ownership interest of each person.
____ 8.	S. 641.406(7)	Complete biographical information, to be submitted on forms provided in this application packet, on all persons controlling 10% or more of the ownership interest of the PHC, and all officers, directors, trustees, partners, or associates of the Prepaid Health Clinic.

Statutory Authority

The requirements for the affiant's social security number (SSN) as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 6 of the Biographical Affidavit, please include the affiant's name and social security on a separate page and attach it to the Biographical Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

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

____ 9.	S. 641.405(2)(c)	Copies of all contracts, past or current, between the PHC and any person listed in item "6", or with any entity of which any of these persons is an officer, director, partner, trustee, or associate, in which he or any member of his family owns 10% or more of stock or other financial interest including any possible conflicts of interest.
____ 10.	S. 641.406(7)	Documentary evidence that the governing body of the PHC has designated a qualified administrator to manage the PHC's operations. This should include a resume of the administrator.

CONTRACTUAL

Statutory Authority		
_____11.	S. 641.405(2)(e)	One copy of every contract, rider, endorsement, certificate, application, or other form the PHC proposes to offer to its subscribers. Follow the list of requirements for individual and group contracts enclosed in this application kit, as well as the requirements in the law concerning the definition of basic services and for PHC contracts. Every subscriber contract must be identified by a unique form number located on the lower left corner of each page of the contract.
____ 12.	S. 641.427	A list of the reasons for which the PHC can terminate a subscriber's contract and the reasons for which the subscriber can terminate his or her contract.
____ 13.	S. 641.405(2)(e)	A table of rates proposed to be charged for each form of subscriber contract.
____ 14.	S. 641.42(5)	A complete description of the procedure established for handling subscriber grievances.

MARKETING

____ 15.	S. 641.405(2)(d)	A statement generally describing the clinic and its operations.
____ 16.	S. 641.441	A copy of all advertising to be used or currently in use. This includes print advertising and scripts for TV or radio advertising.
____ 17.	S. 641.406(4)	A complete explanation of the manner in which the PHC will merchandise subscriber contracts.
____ 18.	S. 641.405(2)(c)	A list of the names and addresses of all sales representatives.
____ 19.	S. 641.405(2)(e)	A statement giving the present (if applicable) projected number of subscribers to be enrolled yearly for the next three years.

FINANCIAL

Statutory Authority

____ 20.	S. 641.406(6)	Executed copies of the insurance policies covering general liability and medical malpractice insurance for the PHC.
____ 21.	S. 641.406(6)	An executed copy of the PHC's fidelity bond covering employee dishonesty.
____ 22.	S. 641.406(6)	If the PHC has secured catastrophic or back-up insurance coverage (reinsurance for the excess loss coverage), you are required to submit executed copies of the policy or policies.
____ 23.	S. 641.405(2)(g)	A current financial statement, including all assets and liabilities of the PHC, also contingent liabilities, unpaid obligations, and actions or suits pending against or anticipated, prepared on the basis of generally accepted accounting principles.
____ 24.	S. 641.407	A statement of the proposed initial working capital reserves of the PHC.
____ 25.	S. 641.405(2)(g)	If your group is already operating as a clinic, a profit and loss statement and balance sheet for the past three years.
____ 26.	S. 641.405(2)(g)	If your group has not been operating as a PHC, a pro-forma (projected) operating statement for the first year and a projected balance sheet (statement of financial position) at the end of the first year.
____ 27.	S. 641.406(3)	The method in which the PHC shall comply with the minimum surplus requirement of Section 641.407, Florida Statutes.
____ 28.	S. 641.405(2)(g)	A cash flow analysis of the PHC for the period until the PHC shows three months of profitability. (If the PHC Is already profitable, provide one year analysis).
____ 29.	S. 641.409(1)(a) S. 641.409(1)(b) S. 641.409(3)	The method in which the PHC shall comply with the minimum surplus requirement of Section 641.409, Florida Statues. All PHCs must make a deposit with the Office of Insurance Regulation in the amount of $30,000. Also, PHCs must purchase insurance or a surety bond in the amount acceptable to the Office, which shall cover the subscribers in the event of insolvency of the PHC.

Statutory Authority

____ 30.	S. 641.406(2)	An actuarial analysis of the rates of the PHC, showing that the proposed rates are actuarially sound for the benefits provided, including administrative costs.
____ 31.	S. 641.405(2)(c)	Copies of all relevant business leases.
____ 32.	S. 641.43	Written contracts identifying each physician or physician group that will be providing service to PHC subscribers. Such contracts must include the hold-harmless clause for subscribers which is required by Section 641.43, Florida Statutes.

This application must be signed by two officers of the PHC and notarized by a notary public.

Signed this_____day of _____, 20 _____.

_____ _____

_____ _____

_____ _____

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

(SEAL) _____

_____

Notary Public

APPLICATION FOR CERTIFICATE OF AUTHORITY MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

CHECK LIST
SECTION I - APPLICATION FEES AND FORM

Company Name: _____

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

APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

SECTION II - LEGAL

Company Name: _____

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

APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

5.	Articles of Incorporation of the Arrangement	❑
	(a) Original and one copy	❑
6.	Bylaws of the Arrangement	❑
	(a) Original and one copy	❑
7.	Certificate of Status of the Arrangement	❑
	(a) Original and one copy	❑

APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

SECTION III - FINANCIAL AND RELATED INFORMATION

Company Name: _____

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

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

(e) Marketing and growth ..... ❑

1. Marketing efforts ..... ❑

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

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

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

3. Fidelity bond ..... ❑

4. Excess insurance agreement ..... ❑

5. Fund balance ..... ❑

6. Feasibility study ..... ❑

(a) Addresses market potential, market penetration, and market competition ..... ❑

(b) Current audited financial statements ..... ❑

(c) Projected income statement ..... ❑

(d) Projected cash flow analysis ..... ❑

(e) Projected balance sheet ..... ❑

(f) Proposed initial cash and cash reserves summary ..... ❑

(g) Insolvency protection deposit requirement ..... ❑

APPLICATION FOR CERTIFICATION OF AUTHORITY MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

SECTION IV - MANAGEMENT

Company Name: _____

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

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

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

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

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

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

(d) Evidence indicating background investigative report has been ordered for all officers, directors and trustees, dated no less than 4 weeks prior to date of application (cancelled check or letter of transmittal) ..... ❑

APPLICATION FOR CERTIFICATE OF AUTHORITY
MULTIPLE EMPLOYER WELFARE ARRANGEMENT

SECTION V - FORMS AND RATES

Company Name: _____

Item #		Completion Check List
1.	Forms	❑
	(a) 3 copies	❑
	(b) Contain assessability language	❑
	(c) Meet flesch score requirements	❑
2.	Marketing material	❑
	(a) Advertising material	❑
	(b) Participating employer application	❑
	(c) Description of association support	❑
3.	Rates to be charged	❑
	(a) 3 copies	❑
4.	Actuarial report	❑
	(a) Prepared by certified actuary	❑
	(b) Prepared in accordance with standards of American Academy of Actuaries	❑
	(c) Includes description of assumptions	❑
	(d) Includes estimation of incurred but not reported claims (IBNR)	❑
	(e) Includes forecast of rates/claims	❑
	(f) Includes certification	❑

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

BIOGRAPHICAL AFFIDAVIT

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

(Print or Type)

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

_____

_____

_____

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

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

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

   Yes ☐ No ☐

   b. Are you a citizen of any other country?

   Yes ☐ No ☐

   If yes, what country? _____

3. Affiant's occupation or profession:_____

4. Affiant's business address:_____

   Business telephone:_____ Business Email: _____

5. Education and training:

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

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

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

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.

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

6. List of memberships in professional societies and associations:

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

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

_____

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

Beginning/Ending Dates (MM/YY):_____-_____ Employer's Name: _____

Address:_____City:_____State/Province: _____

Country:_____Postal Code:_____Phone:_____Offices/Positions Held: _____

Type of Business:_____ Supervisor/Contact: _____

Beginning/Ending Dates (MM/YY):_____-_____ Employer's Name: _____

Address:_____City:_____State/Province: _____

Country:_____Postal Code:_____Phone:_____Offices/Positions Held:_____

Type of Business:_____ Supervisor/Contact: _____

Beginning/Ending Dates (MM/YY):_____-_____ Employer's Name: _____

Address:_____City:_____State/Province: _____

Country:_____Postal Code:_____Phone:_____Offices/Positions Held:_____

Type of Business:_____ Supervisor/Contact: _____

Beginning/Ending Dates (MM/YY):_____-_____ Employer's Name: _____

Address:_____City:_____State/Province: _____

Country:_____Postal Code:_____Phone:_____Offices/Positions Held:_____

Type of Business:_____ Supervisor/Contact: _____

□2015 National Association of Insurance Commissioners

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

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

Yes ☐ No ☐

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

_____

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

Yes ☐ No ☐

If yes, give details: _____

_____

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

_____

_____

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

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

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

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

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

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

_____

_____

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

□2015 National Association of Insurance Commissioners

holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. _____

_____

_____

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

_____

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

Yes ☐ No ☐

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

_____

_____

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

_____

_____

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☐

If yes, provide details: _____

_____

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

Yes ☐ No ☐

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

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

_____

_____

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

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

_____
(Signature of Affiant)

State of:_____County of: _____

The foregoing instrument was acknowledged before me this_____day of_____, 20____by_____,

and:

☐ who is personally known to me, or

☐ who produced the following identification:_____.

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

□2015 National Association of Insurance Commissioners

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

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

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

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

_____

_____

_____

1. Affiant's Full Name (Initials Not Acceptable): First:_____Middle:_____Last:_____
   IF ANSWER IS "NONE," SO STATE.

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

   Yes ☐ No ☐

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

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

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning fromone name to another.

3. Affiant's Social Security Number: _____

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

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

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

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

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

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

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

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

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

_____
(Signature of Affiant)

State of:_____County of: _____

The foregoing instrument was acknowledged before me this_____day of_____, 20____by_____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

□2015 National Association of Insurance Commissioners

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

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS

(All states except California, Minnesota and Oklahoma)

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

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

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

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

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

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

_____
(Printed Full Name and Residence Address)

_____ _____
(Signature) (Date)

State of:_____ County of: _____

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

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

_____
Notary Public

_____

_____

(8/14)
FORM 11

^2015 National Association of Insurance Commissioners

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

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(Minnesota and Oklahoma)

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

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

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

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

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

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

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

_____
(Printed Full Name and Residence Address)

_____ _____

□2015 National Association of Insurance Commissioners

Applicant Company Name : _____ NAIC No. _____

FEIN: _____

(Signature) (Date)

State of:_____ County of: _____

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

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

(8/14)
FORM 11

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

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(California)

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

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

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

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

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

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

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond twelve (12) months following the date of my signature below.

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

_____
(Printed Full Name and Residence Address)

_____ _____
(Signature) (Date)

State of:_____ County of_____

The foregoing instrument was acknowledged before me this___day of_____, 20 by_____, and:
☐ who is personally known to me, or
☐ who produced the following identification: _____

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

Office of Insurance Regulation
Company Admissions

APPLICATION FOR LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

The Office receives applications electronically. Please submit your application at http://www.floir.com/iportal, using the i-Apply 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 SUBMITIED 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/orrates.

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

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

Pursuant to Section 636.Part II, Florida Statutes, in order to do business as a Discount Medical Plan Organization (DMPO), 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 607, Chapter 608, Chapter 617, Chapter 620, or Chapter 865, F.S., and must be licensed by the Office as a discount medical plan organization or be licensed by the Office pursuant to Chapter 624, Part I of 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,

INSTRUCTIONS
SECTION I -APPLICATION FEES AND FORM

Section 1-1 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)(1) and s.636.204(5),F.S.]

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

Florida Department of Financial Services
Bureau of Financial Services
P.O. Box 6100
Tallahassee, Florida 32314-6100

Copy of Check and Invoice
Place a photocopy of the invoice and the check with your application filing. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section 1-2 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. The fingerprint cards are to be submitted with the application filing.

Place a £QQY. of your on-line payment confirmation along with the fingerprint cards in the management section (IV-4).

NOTE: 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.

NOTE: **Individuals who are non-U.S. citizens with no social security number should continue to submit payment of fingerprint fees per instructions in form OIR-Cl-903.**

Section 1-3 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 11-1 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 11-2 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://Vv'\VW.sunbiz.org/.

Important note: The Secretary of State will issue a charter to a discount medical 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 medical plans, or other regulated business.

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

Section 11-3 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 sealed, signed and recently dated by the Secretary of the company. No signatures other than the Secretary's will be accepted.
[s. 636.204(2)(b), F.S.]

Section 11-4 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 11-5 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 111-1 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)0), F.S.]

Section 111-2 Advertising

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

Please note that although advertisements are not required to be filed for prior approval, the company is required to maintain compliance with Rule 690-203.204, which provides standards for advertisements and Rule 690-203.205, which provides advertisement enforcement procedures.

Section 111-3 Website

Prior to licensure by the Office, each DMPO 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 ins. 636.210, F.S.

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

Section 111-4 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 DMPO 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 DMPO 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 DMPO 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 DMPO. 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 DMPO 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 DMPO 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 111-5 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 111-6 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 111-7 A description of the subscriber complaint procedures to be established and maintained. [s. 636.204,(2)(k), F.S.]

SECTION IV - MANAGEMENT

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

Section IV-1 List of All Officers, Directors and Stockholders [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 stockholder 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 DMPO, including any possible conflicts of interest.

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

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

Provide a National Association of Insurance Commissioners (NAIC) biographical affidavit (OIR-C1-1423) for each officer, director, and shareholder listed in Section IV-1 except for those companies in the organizational structure between the immediate parent and the ultimate parent. All questions must be answered. All "Yes" answers must be explained.

Each biographical affidavit must be submitted to the Office containing an original signature and original notary seal. If, however, the biographical affidavits are currently on file and are not more than two years old, no submission is necessary.

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 page 6 of the NAIC form, please include the affiant's name and social security number on a separate page
and attach it to the Biographical Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.071(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 insure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

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

An Investigative Background 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 for instructions.

Section IV-4 Fingerprint Cards

Fingerprint cards must be completed for each person listed in Section IV-1 (except for those companies in the organizational structure between the immediate parent and the ultimate parent). [s.636.204(2)(d),F.S.]

The fingerprint cards along with the fees are due at the time the application is filed. **No cards other than those furnished by the Office will be accepted.** These cards must be completed at a law enforcement or similar type agency and returned to this Office for processing. Please refer to form OIR-C1-938 for instructions.

Note: 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 for instructions.

SECTION V - FORMS AND RATES

NOTE: THE COMPANY CAN SUBMIT ITS FORMS AND RATES ONLY AFTER RECEIVING A NOTICE FROM THIS OFFICE THAT THIS APPLICATION HAS BEEN ACCEPTED. FORMS AND RATES SHOULD BE SUBMITIED TOGETHER IN THE SAME FILING. THE COMPANY IS PROHIBITED FROM WRITING BUSINESS USING UNAPPROVED FORMS OR RATES.

Section V-1 Forms
(See Rule 690-203.203, for Discount Medical Plan Standards)
All form filings shall be submitted to the Office electronically to https://iportal.fldfs.com.

Section V-2 Rates
(See Rule 690-203.204, for Discount Medical Plan Rate Standards)
All rate filings shall be submitted to the Office electronically to https://iportal.fldfs.com.

CHECK LIST
SECTION I - APPLICATION FEES AND FORM

Company Name:_____

Item #	Completion Check list
1. Insurer application fees paid.....	_____
(a) Copy of invoice included (Official Form).....	_____
(b) Copy of check.....	_____
(c) Placed in Section I.....	_____
(d) Originals mailed to Bureau of Financial Services.....	_____
2. Fingerprint fee paid electronically.....	_____
a. Copy of on-line payment confirmation.....	_____

or, if applicable

b. Copy of form OIR-C1-903 (invoice) included....._____

c. Copy of check included....._____

d. Originals mailed to Bureau of Financial Services....._____

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)....._____

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....._____

   (b) If applicable, sealed by corporation....._____

Item # Check List Completion

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....._____

SECTION 111- 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, personal and medical services....._____

7. Description of subscriber complaint procedures....._____

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) "Yes" answers explained.....

(c) Contains original signature.....

Section IV-Management
Required Filing and Check List

Item #	Completion Check list
(d) Notarized (original).....	_____
(e) SSN on a separate page.....	_____

7. Biographical Affidavits for immediate parent(s) officers, directors And shareholders (including entities) owning 10% or more of parent

Company's stock (Form OIR-C1-1423)....._____

As to each biographical:

(a) All blanks completed ..... _____

(b) "Yes" answers explained ..... _____

(c) Contains original signature ..... _____

(d) Notarized (original) ..... _____

(e) SSN on a separate page..... _____

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

As to each biographical:

(a) All blanks completed ..... _____

(b) "Yes" answers explained ..... _____

Section IV-Management
Required Filing and Check List

Item# Completion Check List

(c) Contains original signature ..... _____

(d) Notarized (original) ..... _____

(e) 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....._____

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

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

As to each fingerprint card:

(a) Contains original signature ....._____

(b) Florida cards only ....._____

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

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

As to each fingerprint card:

(a) Contains original signature ....._____

(b) Florida cards only ....._____

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

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

As to each fingerprint card:

(a) Contains original signature ....._____

(b) Florida cards only ....._____

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

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

OIR-C1-1606
Rev 12/05
69O-203.210

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

In order to qualify as a Discount Medical Plan Organization (DMPO), 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 607, Chapter 608, Chapter 617, Chapter 620, or Chapter 865, F.S., and must be licensed by the Office as a discount medical plan organization or be licensed by the Office pursuant to Chapter 624, Part I of 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 Medical Plan Organization:

NAME:_____

ADDRESS: _____

CITY:_____STATE:____ ZIP CODE:_____ -

FEDERAL IDENTIFICATION NUMBER: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

PHONE:_____

CONTACT PERSON: _____

E-MAIL:_ _ _ _ _ _ _ _ _ _ _FAX:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _

ATIORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME:_____

ADDRESS: _____

CITY: _ _ _ _ _ _ _ _ _ _ _STATE: _ _ _ _ _ _ ZIP CODE: _ _ _ _ _

PHONE: _ _ _ _ _ _ _ _ E-MAIL_____ _ _ _ _ _ _

FAX:_ _ _ _ _

OIR-C1-1606
Rev 12/05
69O-203.210

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

_____ (Corporate Seal)
Signature

State of _ _ _ _ _ _ _ _ _ _ _ _ _

County of _____

Sworn to and subscribed before me this ___ day of_____20

_____
Notary Public

(Notary Seal)

_____
My Commission Expires

OIR-C1-1606
Rev 12/05
69O-203.210

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)

OIR-C1-1606
Rev 12/05
69O-203.210

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 the original check for $50 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 32314-6100.
2. Send a copy of the check and a copy of the invoice along with the completed application package to the Office of Insurance Regulation, Applications Coordination Section, 200 East Gaines Street, Larson Building, Tallahassee, Florida 32399-0332.

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

		TY/CL	FIT	AMOUNT
Filing Fee	C	1249F	F	$ 50.00

Department of Financial Services

Office of Insurance Regulation

APPLICATION FOR CERTIFICATE OF AUTHORITY PREPAID LIMITED HEALTH SERVICE ORGANIZATION

This package is designed to assist individuals in preparing the application with all the information required by statute and facilitate expeditious processing of the application by the Office. This package includes five (5) categories of information:

Section I	Application Fees and Form
Section II	Legal
Section III	Financial and Related Information
Section IV	Management
Section V	Forms and Rates

It is extremely important that the application be completed in its entirety in the format specified.

Please submit your package in a binder that has been two-hole punched at the top and place tabs at the bottom of the documents. (Example: the tab labeled II-1 would contain the certified Articles of Incorporation and all amendments).

THE COMPLETED CHECKLIST MUST BE RETURNED WITH THE APPLICATION PACKAGE!

It is recommended that, prior to filing the application, you schedule a pre-filing conference with the Managed Care Section to review any particular problems that our Office has encountered in the past. Although the pre-filing conference is not a statutory requirement, it has proven beneficial to both the applicant and the Office. To schedule a conference, please call (850) 413-2570.

Once the application is complete, mail it to:

Florida Office of Insurance Regulation
Applications Coordination Section
200 East Gaines Street, Larson Building
Tallahassee, Florida 32399-0332

IN ORDER FOR A SUBMISSION TO BE CONSIDERED A COMPLETE APPLICATION, ALL REQUIRED INFORMATION MUST BE INCLUDED IN THE FILING. FILINGS THAT DO NOT INCLUDE ALL REQUIRED INFORMATION WILL BE DISAPPROVED OR RETURNED.

69O-203.100
OIR-C1-1119
(12/05)

APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION

INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORM

Section I-1 Application Fees

Applicants must pay a filing fee of $500.00. The fee is due and payable at the time of filing the application for licensure.

Secure your check to the INVOICE (included in this package) and send to:

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

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

Section I-2 Fingerprint Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-3. The fingerprint cards along with the fees are due at the time the application is filed. A set of instructions for completing the fingerprint cards is included with this package.

Secure your check to the INVOICE (included in this package) and send to:

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

Place a copy of the INVOICE and a copy of the check along with the fingerprint cards in Section (I-2) of the application. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section I-3 Application for Certificate of Authority (Official Form)

On this form, list the lines of business by code (see enclosed classifications and code number form) that you intend to write in the State of Florida. **THE COMPANY MUST BE AUTHORIZED IN ITS STATE OF DOMICILE FOR THE LINES OF BUSINESS THAT ARE BEING REQUESTED.** When a Certificate of Authority is issued by the Office of Insurance Regulation, it will include only those lines listed on this form and addressed in the proformas in the Plan of Operations. This form must be under corporate seal and signed (original signatures) by both the President or Chief Executive Officer and the Secretary of the Company.

APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION

SECTION II - LEGAL

Section II-1 Articles of Incorporation

Include in this section, the applicant's Articles of Incorporation and all amendments. These documents must be certified by the Florida Secretary of State. The certificate must be an original obtained from the Florida Secretary of State's office no earlier than six months prior to the date the application is filed. **SUBMIT AN ORIGINAL AND ONE COPY.**

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

Provide a Certificate of Status. This is a document issued by the Florida Secretary of State. The document certifies that the corporation is duly organized in this State and that all state taxes and fees have been paid. This certificate must be obtained from the Florida Secretary of State's office and be an original. [s. 636.005, F.S.]

If you have any questions concerning filing with the Secretary of State, please contact their Division of Corporations at (850) 245-6051.

Important note: The Secretary of State will issue a charter to a prepaid limited health service organization before the Office of Insurance Regulation completes its processing of an application for a certificate of authority. This charter authorizes the company to engage in any type of business except insurance. **Your company MAY NOT engage in the business of a prepaid limited health service organization in Florida until it has been issued a Certificate of Authority by the Director of Insurance Regulation.**

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

Include two sets of the corporation's By-Laws, Constitution, and/or Rules and Regulations in this section. These documents must be accompanied by a Board Resolution signed and dated by the Secretary of the corporation, stating that the documents are a true and correct copy. **NO** other signatures will be accepted other than the Secretary's signature. **SUBMIT AN ORIGINAL AND ONE COPY.**

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

Provide a Certificate of Compliance. A Certificate of Compliance is a document issued by the public official having supervision of insurance in applicant's state of domicile showing that the company is duly organized and authorized to issue prepaid limited health service contracts therein and the kinds of contracts it is so authorized to transact. The certificate should be an original under seal by the insurer's state of domicile.

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Marketing and Growth

Submit a description of the proposed method of marketing, including the target groups, types of coverage to be offered, advertising media to be used, and contact representatives to be used. Also, submit a detailed marketing budget which reflects the proposed method of marketing for a three-year period. Include such items as compensation, local and out-of-town travel, equipment, printing and postage, advertising and public relations, expense accounts, meeting costs, and any applicable publications.

Section III-2 Advertising

Submit a full disclosure of the PLHSO's proposed advertising. All advertisements shall be available in English and shall include all printed and published material, descriptive literature and sales aids, sales talks and sales material, forms and pamphlets, illustrations, depictions and form letters, newspaper, radio, television, or direct mail. The full name and address of the PLHSO must be clearly contained in all advertisements. Each piece of advertising shall have a unique number or designation which will readily identify it from all other advertising.

Section III-3 Marketing Personnel

Submit a list of licensed health agents to be used initially in soliciting contracts or procuring applications.

Section III-4 Insurance

A. Furnish evidence of adequate insurance coverage (copy of insurance policy) or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of limited health services.

(1) General liability.

(2) Medical malpractice or professional liability.

B. Furnish evidence that a blanket fidelity bond in the amount of at least $50,000. has been obtained (copy of bond). All employees handling the funds must be covered by the blanket fidelity bond. In lieu of the bond, the applicant may deposit with the Office cash or securities or other investments of the types set forth in section 636.042, Florida Statutes.

Section III-5 Financial

A. A copy of the applicant's most recent financial statements audited by an independent certified public accountant.

B. A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of funding, and provisions for contingencies, for which projection all material assumptions shall be disclosed. Financial projections shall include:

(1) A balance sheet.
(2) An income statement.
(3) A cash flow analysis.
(4) A change in financial position.

C. A description of how the applicant will comply with Section 636.046, Florida Statutes.

(1) Each PLHSO shall deposit with the Office cash or securities of the type eligible under Section 625.52, F.S., which shall have at all times a market value of $50,000.

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

D. **Each PLHSO shall at all times maintain a minimum surplus in an amount which is the greater of $150,000 or 10% of total liabilities.**

E. Evidence that the applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. This should include:

(1) Statement of the financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, co-payments, and other patient charges used in connection therewith.

(2) The adequacy of surplus, other sources of funding, and provisions for contingencies.

F. Furnish a statement from a qualified independent actuary that the entity is actuarially sound.

Section III-6 Contractual

A. A copy of the form of all contracts made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees. Include a copy of each type of contract, with a signature page from each executed contract.

B. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of limited health services to enrollees.

C. Copies of all relevant business leases, including rental of real property, equipment, etc. Include the anticipated cost for the life of the lease. If there are no business leases, please so indicate.

Section III-7 Enrollment

Describe the following assumptions underlying enrollment projections:

A. A monthly projection of enrollment for a three-year period.

B. Number of eligibles residing within the service area.

C. Contract size assumptions (contract distribution and content).

D. Penetration assumptions and rationale, including initial enrollments and renewals.

E. Allowance for voluntary/involuntary disenrollment and group contract additions during the year.

F. Date of break even (month, year) based on number of enrollments.

Section III-8 Certificate of Deposit (Foreign Insurers Only)

A Certificate of Deposit is a document issued by the public official having supervision of insurance in the applicant's state of domicile showing the amount and the composition of the deposit maintained by the insurer in another state. The certificate must be an original, sealed by the insurer's state or country of domicile.

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION
SECTION IV - MANAGEMENT

ALL NAMES PROVIDED IN THIS SECTION SHOULD INCLUDE COMPLETE FIRST, MIDDLE AND LAST NAMES (no abbreviations).

Section IV-1 A list of the names (alphabetically), addresses, and official positions of the individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire ten percent or more of the voting securities of the applicant. Such persons shall fully disclose to the Office and to the directors the extent and nature of any contracts or arrangements between them and the PLHSO, including any possible conflicts of interest.

Section IV-2 A list of the owners of the PLHSO, including the extent of the ownership interest of each person or entity and an organizational chart depicting all levels of ownership, including all subsidiaries and parent organizations along with all affiliated companies and corresponding percentages of ownership.

Section IV-3 Biographical Statement and Affidavits, are to be submitted for all officers, directors, managers, and administrators of the PLHSO and all persons controlling and/or owning 10% or more of the ownership interest of the PLHSO. Be sure to include the management positions such as the executive director, medical director, finance director, and marketing director.

A Biographical Statement and Affidavit form (Office of Insurance Regulation Official Form Only) is included in this application package for you to duplicate and use in order to complete this section. All questions must be answered and all "yes" answers must be accompanied by an explanation. Each Biographical Statement and Affidavit must contain an original signature of the principal and an original notary seal. **Please file an original in the order of the list from Section IV-1. Do not retype the DOI Official Biographical Statement and Affidavit form. Retyped forms will not be accepted.**

The requirements for the affiant's social security as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.0721(1) and (8), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 1 of the Biographical affidavit, please include the affiant's name and social security on a separate page and attach it to the Biographical Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.0721(8), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and

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

Section IV-4 An Authority for Release of Information Form must be completed for each person listed in Section IV-3. Each Authority for Release form must contain an original signature of the principal and an original notary seal. **Please file an original of each Authority for Release of Information form in the order of the list provided in Section IV-1.**

Section IV-5 An Investigative Background Report must be provided for each person listed in Section IV-3. These reports must be mailed directly to the Office from the reporting entity. Because the reports are to be paid for by the applicant, please arrange for the billing to be sent by the investigative reporting firm to your accounting office. Instructions for providing these reports are enclosed. If using another reporting entity, please contact that company for instructions.

Evidence indicating that the reports have been ordered for all officers, directors, and trustees must be submitted by the applicant. Acceptable evidence includes a copy of the cancelled check issued to the investigative firm in payment for the reports and a copy of the letter of transmittal to the investigative firm with proof of mailing. The evidence should be dated no less than four (4) weeks prior to the date of the application.

Section IV-6 Fingerprint cards must be completed for each person listed in Section IV-3. The fingerprint cards along with the fees are due at the time the application is filed. **No cards other than those furnished by the Office will be accepted.** These cards must be completed at a law enforcement or similar type agency and returned to this Office for processing. A set of instructions for completing the fingerprint cards is included with this package.

PLEASE NOTE: Information which has been entered on the cards may not be altered in any way, i.e., erased, covered with correction fluid, marked out, etc. In addition, cards may not be folded, stapled, torn or marred in any way.

Section IV-7 A statement generally describing the applicant, its facilities and personnel, and the limited health service to be offered.

Section IV-8 A description of the subscriber complaint procedures to be established and maintained as required under Section 636.038, Florida Statutes.

APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION
SECTION V - FORMS AND RATES

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

Section V-1 Forms

A. Submit three copies of the policy, contract, certificate of coverage, member handbook, application, or any other form the applicant proposes to offer the subscriber. This includes any form showing the benefits to which the subscriber is entitled and any form used in the enrollment process. Every form which the PLHSO will use in connection with its subscriber contracts must be submitted and must be identified by a unique form number located on the lower left corner of the form.

B. Each subscriber contract must state the procedures for offering limited health services and offering and terminating contracts to subscribers which will not unfairly discriminate on the basis of age, sex, race, handicap, health, or economic status.

Section V-2 Rates

Submit three copies of the complete schedule of proposed premium rates for each type of contract. The submission for each separate contract should contain an opinion from a qualified independent actuary or a qualified employee. The opinion shall:

(1) Certify that the rates are neither inadequate nor excessive nor unfairly discriminatory;
(2) Certify that the rates are appropriate for the classes or risks for which they have been computed; and
(3) Present an adequate description of the rating methodology, following consistent and equitable actuarial principles.

APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION

CHECK LIST
SECTION I - APPLICATION FEES AND FORM

Company Name: _____

Item #		Completion Check List
1.	Insurer application fees paid	☐
	(a) Copy of invoice included (Official Form)	☐
	(b) Copy of check	☐
	(c) Placed in Section I	☐
	(d) Originals mailed to Bureau of Financial Services.....	☐
2.	Fingerprint fees paid.....	☐
	(a) Copy of invoice included	☐
	(b) Copy of check	☐
3.	Application for Certificate of Authority (Official Form)	☐
	(a) All blanks completed	☐
	(b) Sealed by corporation	☐
	(c) Signed by President or other authorized officer (original signature)	☐
	(d) Lines of business listed by codes	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION

SECTION II - LEGAL

Company Name: _____

Item #		Completion Check List
1.	Articles of Incorporation and all amendments	☐
	(a) Original certification by Florida Secretary of State	☐
	(b) Articles with all amendments attached	☐
	(c) Original and one copy	☐
2.	Certificate of Status from Florida Secretary of State (original document)	☐
	(a) Good standing indicated	☐
	(b) Sealed by state	☐
	(c) Signed by proper public official	☐
	(d) Original and one copy	☐
2.	Corporate By-Laws, Rules and Regulations, and/or Constitution	☐
	(a) Signed and dated by corporation secretary	☐
	(b) Sealed by corporation	☐
	(c) Original and one copy	☐
	(d) Board Resolution	☐

Section II - Legal
Required Filing and Check List

Item #		Completion Check List
4.	Certificate of Compliance From State or County of domicile	☐
	(a) Original Certification from State of domicile	☐
	(b) Form indicates lines of business the company is authorized to transact	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION

SECTION III - FINANCIAL AND RELATED INFORMATION

Company Name: _____

Item #		Completion Check List
1.	Marketing and growth	☐
	(a) Description of marketing methods.....	☐
	(b) A detailed marketing budget	☐
	(c) List of persons employed to solicit contracts or procure applications.	☐
2.	Advertising	☐
	(a) Include all printed and published material.....	☐
	(b) Sales talks, radio, TV, etc.....	☐
	(c) Full name and address clearly shown.....	☐
	(d) Unique number or designation on each form.....	☐
3.	Marketing personnel	☐
	(a) Submit a list of agents to be used initially.	☐
4.	Insurance	☐
	(a) Current general liability policy or plan for self-insurance.	☐
	(b) Current medical malpractice policy or plan for self-insurance	☐

Section III - Financial and Related Information
Required Filing and Check List

Item #		Completion Check List
5.	Financial	☐
	A. Current audited financial statements	☐
	B. Financial plan and 3 yr. projections	☐
	Anticipated operating results	☐
	Statement of sources of funding	☐
	Provisions for contingencies	☐
	(1) A balance sheet	☐
	(2) An income statement	☐
	(3) A cash flow analysis	☐
	(4) A change in financial position	☐
	C. Evidence of compliance with Section III-5C 1&2.	☐
	D. Compliance with minimum surplus requirement	☐
	E. Statement of soundness of the PLHSO	☐
6.	Contractual Documents	☐
	(a) Provider contract form and signature pages	☐
	(b) Other forms of contracts	☐
	(c) All relevant business leases	☐
7.	Complete enrollment information	☐
	(a) Sections A through F addressed	☐

Section III - Financial and Related Information
Required Filing and Check List

Item #		Completion Check List
8.	Certificate of Deposit	☐
	(a) Original document provided	☐
	(b) Original seal affixed by state of domicile	☐

APPLICATION FOR CERTIFICATION OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION

SECTION IV - MANAGEMENT

Company Name: _____

Item #		Completion Check List
1.	Alphabetical listing of officers, directors, trustees, etc.....	☐
	(a) Separate listing of all officers and directors for the corporation	☐
	(b) Separate listing of trustees and others.....	☐
	(c) Full names listed	☐
	(d) Titles listed.....	☐
2.	A list of the owners of the PLHSO	☐
	(a) Extent of ownership interest of each person or entity.....	☐
	(b) Organizational chart showing all levels of ownership.....	☐
3.	Biographical affidavits for each individual listed in Section IV-3 (Official Form).....	☐
	For each biographical affidavit	
	(a) All blanks completed	☐
	(b) "Yes" answers explained.....	☐
	(c) Contains original signature.....	☐
	(d) Notarized (original)	☐
	(e) Submitted original of each affidavit	☐

Section IV - Management
Required Filing and Check List

Item #		Completion Check List
4.	Authority for Release of Information Forms for each individual listed in Section IV-3 (Official Form)	☐
	(a) Release form contains original signature	☐
	(b) Each release form is Notarized (original)	☐
	(c) Submitted original of each release form	☐
5.	Investigative Background Report for each individual listed in Section IV-3	☐
	(a) Investigative reporting firm contacted	☐
	(b) Full names given to investigative reporting firm for all individuals listed in Section IV-3	☐
	(c) Arrangements made for reports to be sent directly to this Office	☐
	(d) Evidence indicating report has been ordered for all officers, directors and trustees, dated no less than 4 weeks prior to date of application (cancelled check or letter of transmittal)	☐
6.	Fingerprint cards enclosed for each person listed Section IV-3	☐
	(a) Contains original signature	☐
	(b) Card furnished by Office of Insurance Regulation	☐
	(c) No erasures or alterations on cards	☐
	(d) All blanks filled in	☐

Section IV - Management
Required Filing and Check List

Item #		Completion Check List
7.	A statement describing the applicant, facilities and personnel, and service to be offered	☐
8.	Description of subscriber complaint procedures	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION

SECTION V - FORMS AND RATES

Company Name: _____

Item #		Completion Check List
1.	Forms.....	☐
	(a) 3 copies of each.	☐
	(b) Identified by unique form number.....	☐
2.	Rates	☐
	(a) 3 copies of each filing	☐
	(b) Opinion from qualified actuary or employee.....	☐
	(c) Statement of actuarial soundness.....	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY FORM
PREPAID LIMITED HEALTH SERVICE ORGANIZATION

Pursuant to Chapter 636, Florida Statutes, application is hereby submitted to form and operate a Prepaid Limited Health Service Organization.

Proposed name of Prepaid Limited Health Service Organization:

NAME: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

FEDERAL IDENTIFICATION NUMBER: _____

PHONE: _____

CONTACT PERSON: _____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

In order to qualify as a Prepaid Limited Health Service Organization (PLHSO), an entity shall:

(1) Provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers. This **MAY** include ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services **OR** pharmaceutical services.

NOTE: Limited health services shall not include inpatient, hospital surgical services, or emergency services, except as such services are provided incident to the limited health services.

(2) Provide, either directly or through arrangement with other persons, limited health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed sum basis; and

(3) Provide, either directly or through arrangements with other persons, limited health care services to subscribers through a closed panel of providers.

This company, through its duly authorized officers, hereby applies for a certificate of authority authorizing and empowering it to operate as a prepaid limited health service organization in the state of Florida, under the laws thereof, and do hereby swear or affirm that all of the responses, information, exhibits, and documentary evidence submitted in support of this application are true and correct.

Signed this _____ day of _____, 20___

_____
President or other authorized officer
(Please print)

_____ (Corporate Seal)
Signature

State of _____

County of _____

Sworn to and subscribed before me this ____ day of _____20__

_____
Notary Public

(Notary Seal)

_____
My Commission Expires

Application for Certificate of Authority
Prepaid Limited Health Services Organizations
Lines of Business Codes

Lines of Business	Code Numbers
Dental Care Services	451
Ambulance Services	700
Vision Care Services	712
Pharmaceutical Service	716
Mental Health Service	781
Substance Abuse Services	782
Chiropractic Services	783
Podiatric Care Services	784

INVOICE

REQUEST FOR PAYMENT OF APPLICATION FEES

NAME OF PREPAID LIMITED HEALTH SERVICE ORGANIZATION: _____

_____

FEIN# _____ ____

ADDRESS: _____

CITY, STATE & ZIPCODE : _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM ARRANGEMENT ADDRESS)

_____

_____

(CITY) (STATE) (ZIP CODE)

In reference to the submission of the above-referenced insurer's application to do business in Florida, it is necessary for this form to be returned with proper payment.

PLEASE NOTE:

1. Send a check in the proper amount made payable to the Florida Department of Financial Services and mail the check and invoice only to the Florida Department of Financial Services, Bureau of Financial Services, Post Office Box 6100, Tallahassee, Florida 32314-6100.

2. Include a copy of the check and a copy of the invoice with the completed application package that is submitted to the Office of Insurance Regulation, Company Admissions, 200 East Gaines Street, Larson Building, Tallahassee, Florida 32399-0332.

For Accounting Use Only

BIT	TY/CL	F/T	AMOUNT
C	10/36	L	$500.00

690-203.100
OIR-C1-1119
(12/05)

FLORIDA OFFICE OF INSURANCE REGULATION
REPORT OF RESCINDED POLICY

SUBMIT ELECTRONICALLY TO THE
OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS UNIT
HTTP://WWW.FLOIR.COM/IPORTAL
TALLAHASSEE, FL 32399-4210

DATE SUBMITTED _____

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

HAS A CLAIM BEEN FILED ON THIS POLICY YES_____ NO_____

IF YES:

CLAIM NO. _____ DATE_____

CLAIM NO._____ DATE_____

CLAIM NO. _____ DATE _____

CLAIM NO. _____ DATE_____

DATE OF RECISSION OF THIS POLICY _____

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

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

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

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

All Private Passenger Motor Vehicle Insurers in the State of Florida

Electronic Submission of Report of Rescinded Policies

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

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

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

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

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

OFFICE OF INSURANCE REGULATION

Market Investigations

Appendix E

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

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

Due: June 30 annually

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

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

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

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

OFFICE OF INSURANCE REGULATION
Market Investigations

Appendix A

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

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

Due: March 1st - Annually

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

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

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

Detailed reason for rescission:_____

Signature

Name and Title (please type)

Date

Appendix J

Long-Term Care Insurance
Replacement and Lapse Reporting Form

For the State of

For the Reporting Year 20__

Company Name:

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

Company NAIC Number:

Contact Person:

Phone Number: ( ) -

Due: June 30 annually

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

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

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

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

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

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

Company Totals:

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

Form OIR-B2-1555 (Rev. 6/17)
690-157.111

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

PRIVATE PASSENGER AUTOMOBILE EXCESSIVE PROFITS REPORT

COMPANY/GROUP NAME

(COMPLETE FOR FIRST 3 VALUATION DATES)

FL CERT OF AUTHORITY

ACCIDENT YEAR

AS OF 3/31

VALUATION YEAR

(CHECK ONE)

☐ (A1) VOLUNTARY BUSINESS

☐ (A2) FJUA BUSINESS

☐ SPECIFY NUMBER OF COMPANIES INCLUDED IN THIS REPORT

ITEM DESCRIPTION	(1) BI	(2) PIP	(3) PD	(4) UM	(5) MP	(6) COMP	(7) COLL
(1) CAL. YR. TOTAL LIMITS WRITTEN PREMIUM							
(2) CAL. YR. TOTAL LIMITS EARNED PREMIUM							
(3) ACC. YR. TOTAL LIMITS PAID LOSSES							
(4) ACC. YR. TOTAL LIMITS CASE LOSS RESERVES							
(5) ACC. YR. TOTAL LIMITS IBNR LOSS RESERVES							
(6) ALLOCATED LOSS ADJUSTMENT EXPENSE PAID							
(7) ALLOCATED LOSS ADJUSTMENT EXPENSE RESERVES							
(8) UNALLOCATED LOSS ADJUSTMENT EXPENSE INCURRED							
(9) CAL. YR. POLICYHOLDER DIVIDENDS INCURRED							
(10) OTHER ACQUISITION EXPENSES							
(11) GENERAL EXPENSES							
(12) EXPENSES FOR AGENTS COMMISSIONS							
(13) EXPENSES FOR TAXES, LICENSES & FEES							
*****CONTROL TOTALS***** (SUM OF ITEMS 1 - 13 FOR EACH COLUMN)							
(14) INCURRED LOSS DEVELOPMENT FACTOR**							
(15) ALLOCATED L.A.E. DEVELOPMENT FACTOR**							
(16) FACTOR FOR PROFIT AND CONTINGENCIES**							

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

**ALL FACTORS MUST BE SHOWN TO THREE DECIMAL PLACES, EXAMPLE: 1.200 OR 0.986 OR 0.015. (ATTACH DERIVATIONS FOR DEVELOPMENT FACTORS.)

PRIVATE PASSENGER AUTOMOBILE
LOSS RESERVE COMPARISON REPORT

_____
COMPANY/GROUP NAME

(COMPLETE FOR LAST 4 VALUATION DATES)

| | | |

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

PRIVATE PASSENGER AUTOMOBILE EXCESSIVE PROFITS

CERTIFICATION

I,_____,_____
(Name of Officer) (Title)

of_____do hereby certify
(Company/Group Name)

that the information on the Private Passenger Automobile Excessive Profits Reporting Form DI4-307 is a full and true statement of the experience of the said insurer and that the form has been completed in accordance with instructions provided. I also acknowledge that I understand that this data is being provided in accordance with Section 627.066, Florida Statutes and will be used to calculate excessive profits in accordance with this statute.

_____ _____
(Signature) (Date)

Note: This certification must be signed by a company officer having appropriate authority.

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

INSTRUCTION SHEET

GENERAL INSTRUCTIONS

A. Data is to be reported by company or by group if under common management. A list of all companies included in the report and their 5 digit Florida certificate of authority number should be provided. If you are filing on a group basis, use the Florida certificate of authority number of the company that has the largest private passenger premium volume.
B. Fill out the forms completely including the coding boxes at the top of the pages.
C. The types of coverage are:
   (1) BI = Bodily Injury Liability
   (2) PIP = Personal Injury Protection
   (3) PD = Property Damage Liability
   (4) UM = Uninsured Motorists
   (5) MP = Medical Payments
   (6) COMP = Comprehensive
   (7) COLL = Collision
D. If coverages are written on a combined basis and the data cannot be separated, then code this data under the most appropriate individual coverage. Miscellaneous coverages should be coded under the most appropriate individual coverage. (Example: Towing should be reported under Comprehensive.) Include an explanation in the cover letter of your report whenever necessary. NOTE: All coverages must be reported.
E. Every company writing private passenger automobile business in Florida must report their data. There are no exceptions. Do not report data for Commercial Auto, Mobile Homes, Motorcycles, Vendors Single Interest, or Unlicensed Recreational Vehicles.
F. Negative amounts should be placed in parenthesis. Zero amounts should be shown as "-0-".
G. Forms are due July 1 of each year. Send your forms to:

Office of Insurance Regulation
Bureau of Property/Casualty Forms and Rates
Private Passenger Auto Section
200 East Gaines Street
Tallahassee, FL 32399-0330

PAGE 1- PRIVATE PASSENGER AUTOMOBILE EXCESSIVE PROFITS REPORT

A. File a separate form for each accident year for voluntary business and for Florida Joint Underwriting Association (FJUA) business. If you authorize the Automobile Insurance Plan Service Office (AIPSO) to file the FJUA business on your behalf then you do not need to complete this form for your FJUA business.

B. Each report should include data from three (3) accident years. For example, your 1989 report (i.e., the report due July 1, 1989 with data evaluated as of 3-31-89) should include data from accident years 1986, 1987, and 1988 evaluated as of 3-31-89. Your 1990 report should include data from accident years 1987, 1988, and 1989 evaluated as of 3-31-90.

C. If you report Accident Year Total Limits IBNR Loss Reserves in item (5), provide appropriate supporting data for these figures. If you do not report IBNR Loss Reserves enter "-0-".

D. Provide an explanation of the methodology involved in the determination of the Allocated Loss Adjustment Expenses Reserves reported in item (7) including appropriate supporting data.

E. Provide an explanation of the methodology involved in the determination of the Unallocated Loss Adjustment Expenses Incurred reported in item (8) including appropriate supporting data.

F. If Calendar Year Policyholder Dividends Incurred are reported in item (9), explain how the dollar amounts were determined.

G. Provide an explanation of the methodology involved in the determination of the Other Acquisition Expenses reported in item (10) including appropriate supporting data.

H. Provide an explanation of the methodology involved in the determination of the General Expenses reported in item (11) including appropriate supporting data.

I. Provide an explanation of the methodology involved in the determination of the Expenses for Agent's Commissions reported in item (12) including appropriate supporting data.

J. Provide an explanation of the methodology involved in the determination of the Expenses for Taxes, Licenses and Fees reported in item (13) including appropriate supporting data.

K. Provide an explanation of the methodology involved in the determination of the Incurred Loss Development Factors reported in item (14) including appropriate supporting data. This data should be consistent with the incurred losses to which the factors are applied. Note – the Incurred Loss Development Factors are multiplied by the sum of items (3), (4), and (5).

L. Provide an explanation of the methodology involved in the determination of the Allocated Loss Adjustment Expense Development Factors reported in item (15) including appropriate supporting data. This data should be consistent with the allocated loss adjustment expenses to which the factors are applied. Note – the Allocated Loss Adjustment Expense Development Factors are applied to the sum of items (6) and (7).

M. Show how the budgeted Factors for Profit and Contingencies reported in item (16) were determined. Note – these factors should track with the rate filings in effect during the particular calendar year and should reflect investment income.

PAGE 2 - PRIVATE PASSENGER AUTOMOBILE EXCESSIVE PROFITS REPORTS

A. Page 2 requires the reporting of accident year loss and loss adjustment expense data with evaluations as of 51, 63, 75, and 87 months from the beginning of each accident year. When combined with Page 1, this results in the loss and loss adjustment expense data for each accident year being reported at seven (7) evaluation dates.
B. File a separate report for each accident year for voluntary business only.
C. Each report should include data from four (4) accident years. For example, your 1989 Report (i.e., the report due July 1, 1989 with data evaluated as of 3-31-89) should include data from accident years 1982, 1983, 1984, and 1985 evaluated as of 3-31-89. Your 1990 Report should include data from accident years 1983, 1984, 1985, and 1986 evaluated as of 3-31-90.
D. Items (1) through (6) on Page 2 should be consistent with items (3) through (8) on Page 1 and the methodology involved in the determination of these figures should be the same as the methodology involved in the determination of the figures on Page 1.
E. If Accident Year Total Limits IBNR Loss Reserves are reported on Page 1, then they should also be reported on Page 2. If you do not report IBNR Loss Reserves on Page 1, then you should enter "-0-" on Page 1 and Page 2.

FORM DI4-307 CERTIFICATION

This certification should accompany each report and should be completed and signed by a company officer having appropriate authority.

FLORIDA PROPERTY & CASUALTY - QUARTERLY REPORT
INDIVIDUALLY RATED RISKS
("A" RATES) - (CONSENT-TO-RATE - EXCESS RATE)

☐ 1st Quarter ☐ 2nd Quarter

☐ 3rd Quarter ☐ 4th Quarter

☐ Company has not been subject to filing this form for the past four consecutive quarters.

1. FEIN (Lead Company): ☐☐-☐☐☐☐☐☐☐
2. Group Name: _____
3. Company Name: _____
4. Mailing Address: _____

   _____
5. Contact Person:

   Phone Number: _____

   _____
6. Chief Executive Officer's Name:

   Mailing Address: _____

   _____
7. Provide your FAX number: _____

   800 number: _____
8. Total number of policies: _____
9. I certify that I am authorized to make this Individually Rated Risk/Consent-to-Rate filing on behalf of the company, further that the information contained in related transmittals and the filing is true, complete, correct and, to the best of my knowledge, in compliance with all applicable state laws.

_____ _____
Signature Date

_____ _____
Type Name Position with company (Title

PROPERTY & CASUALTY
INDIVIDUALLY RATED RISK
QUARTERLY REPORT

Company Name:

_____

Complete a separate report for each quarter beginning January 1 (1st quarter of January, February, March, 1993). The first report due May 15, 1993. The reports are due 45 days after the close of each quarter.

INDIVIDUALLY RATED ("A" RATE)

Total Number of Policies Individually Rated ("A" Rate)

_____

Total Direct Written Premium ("A" Rate)

_____

CONSENT-TO-RATE (EXCESS RATE)

Total Number of Policies Individually Rated (Consent-to-Rate)

_____

Total Direct Written Premium (Consent-to-Rate)

_____

69O-154

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

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

627.6425 Renewability of individual coverage.—
(1) Except as otherwise provided in this section, an insurer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual. For the purpose of this section, the term "individual health insurance" means health insurance coverage, as described in s. 624.603, offered to an individual in this state, including certificates of coverage offered to individuals in this state as part of a group policy issued to an association outside this state, but the term does not include short-term limited duration insurance or excepted benefits specified in s. 627.6513(1)-(14).
(2) An insurer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:
(a) The individual has failed to pay premiums, contributions, or a required copayment payable to the insurer in accordance with the terms of the health insurance coverage or the insurer has not received timely premium payments. When the copayment is payable to the insurer and exceeds $300, the insurer shall allow the insured up to 90 days after the date of the procedure to pay the required copayment. The insurer shall print in 10-point type on the Declaration of Benefits page notification that the insured could be terminated for failure to make any required copayment to the insurer.
(b) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
(c) The insurer is ceasing to offer coverage in the individual market in accordance with subsection (3) and applicable state law.
(d) In the case of a health insurer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area, or in an area for which the insurer is authorized to do business, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor of covered individuals.
(e) In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, as defined in s. 627.6571(5), the membership of the individual in the association, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor of covered individuals.
(3)(a) If an insurer decides to discontinue offering a particular policy form for health insurance coverage offered in the individual market, coverage under such form may be discontinued by the insurer only if:
1. The insurer provides notice to each covered individual provided coverage under this policy form in the individual market of such discontinuation at least 90 days before the date of the nonrenewal of such coverage;

2. The insurer offers to each individual in the individual market provided coverage under this policy form the option to purchase any other individual health insurance coverage currently being offered by the insurer for individuals in such market in the state; and
3. In exercising the option to discontinue coverage of a policy form and in offering the option of coverage under subparagraph 2., the insurer acts uniformly without regard to any health-status-related factor of enrolled individuals or individuals who may become eligible for such coverage. If a policy form covers both grandfathered and nongrandfathered health plans, an insurer may nonrenew coverage only for the nongrandfathered health plans, in which case the requirements of subparagraphs 1. and 2. apply only to the nongrandfathered health plans. As used in this subparagraph, the terms "grandfathered health plan" and "nongrandfathered health plan" have the same meaning as provided in s. 627.402.
(b)1. Subject to subparagraph (a)3., in any case in which an insurer elects to discontinue offering all health insurance coverage in the individual market in this state, health insurance coverage may be discontinued by the insurer only if:
a. The insurer provides notice to the office and to each individual of such discontinuation at least 180 days prior to the date of the nonrenewal of such coverage; and
b. All health insurance issued or delivered for issuance in the state in the individual market is discontinued and coverage under such health insurance coverage in such market is not renewed.
2. In the case of a discontinuation under subparagraph 1. in the individual market, the insurer may not provide for the issuance of any individual health insurance coverage in this state during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.
(4) At the time of coverage renewal, an insurer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with the laws of this state and effective on a uniform basis among all individuals with that policy form.
(5) In applying this section in the case of health insurance coverage that is made available by an insurer in the individual market to individuals only through one or more associations, a reference to an "individual" includes a reference to such an association of which the individual is a member.
(6) This section applies to health insurance coverage offered, sold, issued, or renewed in the individual market on or after July 1, 1997.

627.6692 Florida Health Insurance Coverage Continuation Act.—

(5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.—
(a) A group health plan issued to a small employer must provide that each qualified beneficiary who would lose coverage under the group health plan because of a qualifying event is entitled, without evidence of insurability, to elect, within the election period provided in this section, continuation coverage under the employer's group health plan. A qualified beneficiary who elects continuation coverage is subject to all the terms and conditions applicable under the group health plan.
(b) Coverage under the group health plan must, at a minimum, extend for the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:
1. The date that is 18 months after the date on which the qualified beneficiary's benefits under the group health plan would otherwise have ceased because of a qualifying event.
2. The date on which coverage ceases under the group health plan by reason of a failure to make timely payment of the applicable premium with respect to any qualified beneficiary.
3. The date a qualified beneficiary becomes covered under any other group health plan, if the qualified beneficiary will not be subject to any exclusion or limitation because of a preexisting condition of that beneficiary.

4. The date a qualified beneficiary is entitled to benefits under either part A or part B of Title XVIII of the Social Security Act (Medicare).
5. The date on which the employer terminates coverage under the group health plan for all employees. If the employer terminates coverage under the group health plan for all employees and if such group health plan is replaced by similar coverage under another group health plan, the qualified beneficiary shall have the right to become covered under the new group health plan for the balance of the period that she or he would have remained covered under the prior group health plan. A qualified beneficiary is to be treated in the same manner as an active beneficiary for whom a qualifying event has not taken place.
(c) A qualified beneficiary who is determined, under Title II or Title XVI of the Social Security Act, to have been disabled at the time of a qualifying event, may be eligible to continue coverage for an additional 11 months (29 months total) if the qualified beneficiary provides the written determination of disability from the Social Security Administration to the insurance carrier within 60 days of the date of determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. The insurance carrier can charge up to 150 percent of the group rate during the 11-month disability extension. The qualified beneficiary must notify the insurance carrier within 30 days upon the determination that the qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act.
(d)1. A qualified beneficiary must give written notice to the insurance carrier within 63 days after the occurrence of a qualifying event. Unless otherwise specified in the notice, a notice by any qualified beneficiary constitutes notice on behalf of all qualified beneficiaries. The written notice must inform the insurance carrier of the occurrence and type of the qualifying event giving rise to the potential election by a qualified beneficiary of continuation of coverage under the group health plan issued by that insurance carrier, except that in cases where the covered employee has been involuntarily discharged, the nature of such discharge need not be disclosed. The written notice must, at a minimum, identify the employer, the group health plan number, the name and address of all qualified beneficiaries, and such other information required by the insurance carrier under the terms of the group health plan or the commission by rule, to the extent that such information is known by the qualified beneficiary.
2. Within 14 days after the receipt of written notice under subparagraph 1., the insurance carrier shall send each qualified beneficiary by certified mail an election and premium notice form, approved by the office, which form must provide for the qualified beneficiary's election or nonelection of continuation of coverage under the group health plan and the applicable premium amount due after the election to continue coverage. This subparagraph does not require separate mailing of notices to qualified beneficiaries residing in the same household, but requires a separate mailing for each separate household.
(e)1. A covered employee or other qualified beneficiary who wishes continuation of coverage must pay the initial premium and elect such continuation in writing to the insurance carrier issuing the employer's group health plan within 30 days after receiving notice from the insurance carrier under paragraph (d). Subsequent premiums are due by the grace period expiration date. The insurance carrier or the insurance carrier's designee shall process all elections promptly and provide coverage retroactively to the date coverage would otherwise have terminated. The premium due shall be for the period beginning on the date coverage would have otherwise terminated due to the qualifying event. The first premium payment must include the coverage paid to the end of the month in which the first payment is made. After the election, the insurance carrier must bill the qualified beneficiary for premiums once each month, with a due date on the first of the month of coverage and allowing a 30-day grace period for payment.
2. Except as otherwise specified in an election, any election by a qualified beneficiary shall be deemed to include an election of continuation of coverage on behalf of any other qualified beneficiary residing in the same household who would lose coverage under the

group health plan by reason of a qualifying event. This subparagraph does not preclude a qualified beneficiary from electing continuation of coverage on behalf of any other qualified beneficiary.
(f) The premium paid for continuation of coverage may not exceed 115 percent of the applicable premium.
(g) If an insurance carrier fails to comply with the notice requirements of subparagraph (d)2. and such noncompliance results in the failure of an eligible qualified beneficiary to elect continuation under the group health plan, the qualified beneficiary shall be deemed to have timely elected continuation of coverage within the election period and shall be covered under the group health plan at the expense of the noncomplying insurance carrier. The liability exposure of a noncomplying insurance carrier under this paragraph shall be limited to that period which includes the effective date of coverage pursuant to an affirmative election through the date on which the qualified beneficiary receives actual notice. This paragraph does not apply to the extent that the failure of the insurance carrier to comply with applicable notice requirements was due to noncompliance by the qualified beneficiary with notice requirements applicable to the qualified beneficiary.
(h) If a covered employee is in the military reserve or National Guard and is called to active duty and the employee's employment is terminated either after or during the active duty period, the termination is a separate qualifying event, distinct from the qualifying event that may have occurred when the employee was called to active duty, and the employee and other qualified beneficiaries are eligible for a new 18-month benefit period beginning on the later of the date active duty ends or the date of termination of employment.
(i) If a covered employee is in the military reserve or National Guard and is called to active duty and:
1. The employee dies during the period of active duty,
2. There is a divorce or legal separation of the covered employee from the covered employee's spouse, or
3. A dependent child ceases to be a dependent child under the requirements of the employer's group health plan,

such events are qualifying events distinct from the qualifying event that may have occurred when the employee was called to active duty.

(j) Notwithstanding paragraph (b), if a qualified beneficiary in the military reserve or National Guard has elected to continue coverage and is thereafter called to active duty and the coverage under the group plan is terminated by the beneficiary or the carrier due to the qualified beneficiary becoming eligible for TRICARE (the health care program provided by the United States Defense Department), the 18-month period or such other applicable maximum time period for which the qualified beneficiary would otherwise be entitled to continue coverage is tolled during the time that he or she is covered under the TRICARE program. Within 63 days after the federal TRICARE coverage terminates, the qualified beneficiary may elect to continue coverage under the group health plan, retroactively to the date coverage terminated under TRICARE, for the remainder of the 18-month period or such other applicable time period, subject to termination of coverage at the earliest of the conditions specified in paragraph (b).

(9) RULES.—The commission shall adopt rules establishing standards for the initial notice of rights and as otherwise necessary to administer this section.

641.36 Adoption of rules; penalty for violation.—The commission shall adopt rules necessary to carry out the provisions of this part. The office shall collect and make available all health maintenance organization rules adopted by the commission. Any violation of a rule adopted under this section shall subject the violating entity to the provisions of s. 641.23.

[1]627.410 Filing, approval of forms.—
(1) A basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, group certificates issued under a master contract delivered in this state, or printed rider or endorsement form or form of renewal certificate, may not be delivered or issued for delivery in this state unless the form has been filed with the office by or on behalf of the insurer that proposes to use such form and has been approved by the office or filed pursuant to s. 627.4102. This provision does not apply to surety bonds or to policies, riders, endorsements, or forms of unique character that are designed for and used with insurance on a particular subject, other than as to health insurance, or that relate to the manner of distributing benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificateholder. For group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the office for information purposes only.
(2) Every such filing must be made at least 30 days in advance of any such use or delivery. At the expiration of the 30 days, the form filed will be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the office. The approval of such form by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend the period within which it may affirmatively approve or disapprove such form by up to 15 days by giving notice of such extension before expiration of the initial 30-day period. At the expiration of such extended period, and in the absence of prior affirmative approval or disapproval, such form shall be deemed approved.
(3) The office may, for cause, withdraw a previous approval. No insurer shall issue or use any form disapproved by the office, or as to which the office has withdrawn approval, after the effective date of the order of the office.
(4) The office may, by order, exempt from the requirements of this section for so long as it deems proper any insurance document or form or type thereof as specified in such order, to which, in its opinion, this section may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public.
(5) This section also applies to any such form used by domestic insurers for delivery in a jurisdiction outside this state if the insurance supervisory official of such jurisdiction informs the office that such form is not subject to approval or disapproval by such official, and upon the order of the office requiring the form to be submitted to it for the purpose. The applicable same standards apply to such forms as apply to forms for domestic use.
(6)(a) An insurer may not deliver, issue for delivery, or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the office applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.
(b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health

insurance policy form or type thereof, as specified in such rule, to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 are for informational purposes.

(c) Every filing made pursuant to this subsection shall be made within the same time period, and shall be deemed to be approved under the same conditions, as provided in subsection (2).

(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, is prohibited from applying the following rating practices:

1. Select and ultimate premium schedules.

2. Premium class definitions that classify insured based on year of issue or duration since issue.

3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.

(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form is not considered to be available for purchase unless the insurer has actively offered it for sale during the previous 12 months.

1. An insurer may discontinue the availability of a policy form if the insurer provides its decision to the office in writing at least 30 days before discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer may no longer offer the policy form or certificate form for sale in this state.

2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. may not file for approval a new policy form providing benefits similar to the discontinued form for 5 years after the insurer provides notice to the office of the discontinuance. The period of discontinuance may be reduced if the office determines that a shorter period is appropriate. The requirements of this subparagraph do not apply to the discontinuance of a policy form because it does not comply with PPACA.

3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes, except that the experience of grandfathered health plans and nongrandfathered health plans shall be separated.

(7) Each insurer subject to subsection (6) shall make an annual filing with the office within 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. After receiving a request to be exempted from the provisions of this section, the office may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(a) The filing shall be satisfied by one of the following methods:

1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules adopted by the commission.

2. If no rate change is proposed, a filing that consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the commission.

(b) As used in this section, the term "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants who have a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.

(c) If at the time a filing is required an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office by the date the filing is due.
(d) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days after the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made until such time as the office determines that the required filing is properly submitted.
(8)(a) For the purposes of subsections (6) and (7), benefits of an individual accident and health insurance policy form, including Medicare supplement policies as defined in s. 627.672, when authorized by rules adopted by the commission, and excluding long-term care insurance policies as defined in s. 627.9404, and other policy forms under which more than 50 percent of the policies are issued to individuals age 65 and over, are deemed to be reasonable in relation to premium rates if the rates are filed pursuant to a loss ratio guarantee and both the initial rates and the durational and lifetime loss ratios have been approved by the office, and such benefits shall continue to be deemed reasonable for renewal rates while the insurer complies with such guarantee, provided the currently expected lifetime loss ratio is not more than 5 percent less than the filed lifetime loss ratio as certified to by an actuary. The office shall have the right to bring an administrative action should it deem that the lifetime loss ratio will not be met. For Medicare supplement filings, the office may withdraw a previously approved filing which was made pursuant to a loss ratio guarantee if it determines that the filing is not in compliance with ss. 627.671-627.675 or the currently expected lifetime loss ratio is less than the filed lifetime loss ratio as certified by an actuary in the initial guaranteed loss ratio filing. If this section conflicts with ss. 627.671-627.675, ss. 627.671-627.675 shall control.
(b) The renewal premium rates shall be deemed to be approved upon filing with the office if the filing is accompanied by the most current approved loss ratio guarantee. The loss ratio guarantee shall be in writing, shall be signed by an officer of the insurer, and shall contain at least:
1. A recitation of the anticipated lifetime and durational target loss ratios contained in the actuarial memorandum filed with the policy form when it was originally approved. The durational target loss ratios shall be calculated for 1-year experience periods. If statutory changes have rendered any portion of such actuarial memorandum obsolete, the loss ratio guarantee shall also include an amendment to the actuarial memorandum reflecting current law and containing new lifetime and durational loss ratio targets.
2. A guarantee that the applicable loss ratios for the experience period in which the new rates will take effect, and for each experience period thereafter until new rates are filed, will meet the loss ratios referred to in subparagraph 1.
3. A guarantee that the applicable loss ratio results for the experience period will be independently audited at the insurer's expense. The audit shall be performed in the second calendar quarter of the year following the end of the experience period, and the audited results shall be reported to the office no later than the end of such quarter. The commission shall establish by rule the minimum information reasonably necessary to be included in the report. The audit shall be done in accordance with accepted accounting and actuarial principles.
4. A guarantee that affected policyholders in this state shall be issued a proportional refund, based on the premium earned, of the amount necessary to bring the applicable experience period loss ratio up to the durational target loss ratio referred to in subparagraph 1. The refund shall be made to all policyholders in this state who are insured under the applicable policy form as of the last day of the experience period, except that no refund need be made to a policyholder in an amount less than $10. Refunds less than $10 shall be aggregated and paid pro rata to the policyholders receiving refunds. The refund

shall include interest at the then-current variable loan interest rate for life insurance policies established by the National Association of Insurance Commissioners, from the end of the experience period until the date of payment. Payments shall be made during the third calendar quarter of the year following the experience period for which a refund is determined to be due. However, no refunds shall be made until 60 days after the filing of the audit report in order that the office has adequate time to review the report.
5. A guarantee that if the applicable loss ratio exceeds the durational target loss ratio for that experience period by more than 20 percent, provided there are at least 2,000 policyholders on the form nationwide or, if not, then accumulated each calendar year until 2,000 policyholder years is reached, the insurer, if directed by the office, shall withdraw the policy form for the purposes of issuing new policies.
(c) As used in this subsection:
1. "Loss ratio" means the ratio of incurred claims to earned premium.
2. "Applicable loss ratio" means the loss ratio attributable solely to this state if there are 2,000 or more policyholders in the state. If there are 500 or more policyholders in this state but less than 2,000, it is the linear interpolation of the nationwide loss ratio and the loss ratio for this state. If there are less than 500 policyholders in this state, it is the nationwide loss ratio.
3. "Experience period" means the period, ordinarily a calendar year, for which a loss ratio guarantee is calculated.

627.6571 Guaranteed renewability of coverage.—

(3) (b)1. In any case in which an insurer elects to discontinue offering all health insurance coverage in the small-group market or the large-group market, or both, in this state, health insurance coverage may be discontinued by the insurer only if:

a. The insurer provides notice to the office and to each policyholder, and participants and beneficiaries covered under such coverage, of such discontinuation at least 180 days prior to the date of the nonrenewal of such coverage; and
b. All health insurance issued or delivered for issuance in this state in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.
2. In the case of a discontinuation under subparagraph 1. in a market, the insurer may not provide for the issuance of any health insurance coverage in the market in this state during the 5-year period beginning on the date of the discontinuation of the last insurance coverage not renewed.
(c) A mailing to one household constitutes a mailing to all covered persons residing in that household. A separate mailing is required for each separate household.

641.31074 Guaranteed renewability of coverage.—
(1) Except as otherwise provided in this section, a health maintenance organization that issues a health insurance contract must renew or continue in force such coverage at the option of the contract holder.
(2) A health maintenance organization may nonrenew or discontinue a contract based only on one or more of the following conditions:
(a) The contract holder has failed to pay premiums or contributions in accordance with the terms of the contract or the health maintenance organization has not received timely premium payments.
(b) The contract holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the contract.

(c) The contract holder has failed to comply with a material provision of the plan which relates to rules for employer contributions or group participation.
(d) The health maintenance organization is ceasing to offer coverage in such a market in accordance with subsection (3).
(e) There is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the health maintenance organization or in the area in which the health maintenance organization is authorized to do business.
(f) In the case of coverage that is made available only through one or more bona fide associations as defined in s. 627.6571(5), the membership of an employer in the association, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor that relates to any covered individuals.
(3)(a) A health maintenance organization may discontinue offering a particular contract form only if:
1. The health maintenance organization provides notice to each contract holder provided coverage of this form in such market, and participants and beneficiaries covered under such coverage, of such discontinuation at least 90 days prior to the date of the nonrenewal of such coverage;
2. The health maintenance organization offers to each contract holder provided coverage of this form in such market the option to purchase all, or in the case of the large group market, any other health insurance coverage currently being offered by the health maintenance organization in such market; and
3. In exercising the option to discontinue coverage of this form and in offering the option of coverage under subparagraph 2., the health maintenance organization acts uniformly without regard to the claims experience of those contract holders or any health-status-related factor that relates to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.
(b)1. In any case in which a health maintenance organization elects to discontinue offering all coverage in the individual market, the small group market, the large group market, or any combination thereof in this state, coverage may be discontinued by the insurer only if:
a. The health maintenance organization provides notice to the office and to each contract holder, and participants and beneficiaries covered under such coverage, of such discontinuation at least 180 days prior to the date of the nonrenewal of such coverage; and
b. All health insurance issued or delivered for issuance in this state in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.
2. In the case of a discontinuation under subparagraph 1. in a market, the health maintenance organization may not provide for the issuance of any health maintenance organization contract coverage in the market in this state during the 5-year period beginning on the date of the discontinuation of the last insurance contract not renewed.
(4) At the time of coverage renewal, a health maintenance organization may modify the coverage for a product offered:
(a) In the large group market;
(b) In the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, as defined in s. 627.6571(5), such modification is consistent with s. 627.6699 and effective on a uniform basis among group health plans with that product; or
(c) In the individual market if the modification is consistent with the laws of this state and effective on a uniform basis among all individuals with that policy form.
(5) In applying this section in the case of health insurance coverage that is made available by a health maintenance organization in the small group market or large group market to employers only through one or more associations, a reference to "contract holder" is

deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless

the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive

years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:

1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

690-149 Rulemaking Authority

627.6699 Employee Health Care Access Act.—

(9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER OR A REINSURING CARRIER.—
(a) A small employer carrier must elect to become either a risk-assuming carrier or a reinsuring carrier. By October 31, 1993, all small employer carriers must file a final election, which is binding for 2 years, from January 1, 1994, through December 31, 1995, after which an election shall be binding for a period of 5 years. Any carrier that is not a small employer carrier and intends to become a small employer carrier must file its designation when it files the forms and rates it intends to use for small employer group health insurance; such designation shall be binding for 2 years after the date of approval of the forms and rates, and any subsequent designation is binding for 5 years. The office may permit a carrier to modify its election at any time for good cause shown, after a hearing.
(b) The commission shall establish an application process for small employer carriers seeking to change their status under this subsection.
(c) An election to become a risk-assuming carrier is subject to approval under subsection (10).
(d) A small employer carrier that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier is prohibited from reinsuring or continuing to reinsure any small employer health benefits plan under subsection (11) as soon as the carrier becomes a risk-assuming carrier and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. A small employer carrier that elects to cease participating as a risk-assuming carrier and to become a reinsuring carrier is permitted to reinsure small employer health benefit plans under the terms set forth in subsection (11) and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.
(10) ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.—
(a)1. A small employer carrier may become a risk-assuming carrier by filing with the office a designation of election under subsection (9) in a format and manner prescribed by the commission. The office shall approve the election of a small employer carrier to become a risk-assuming carrier if the office finds that the carrier is capable of assuming that status pursuant to the criteria set forth in paragraph (b).
2. The office must approve or disapprove any designation as a risk-assuming carrier within 60 days after filing.
(b) In determining whether to approve an application by a small employer carrier to become a risk-assuming carrier, the office shall consider:
1. The carrier's financial ability to support the assumption of the risk of small employer groups.
2. The carrier's history of rating and underwriting small employer groups.
3. The carrier's commitment to market fairly to all small employers in the state or its service area, as applicable.
4. The carrier's ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance program provided in subsection (11).
(c) A small employer carrier that becomes a risk-assuming carrier pursuant to this subsection is not subject to the assessment provisions of subsection (11).
(d) The office shall provide public notice of a small employer carrier's designation of election under subsection (9) to become a risk-assuming carrier and shall provide at least a 21-day period for public comment prior to making a decision on the election. The office shall hold a hearing on the election at the request of the carrier.

(e) The office may rescind the approval granted to a risk-assuming carrier under this subsection if the office finds that the carrier no longer meets the criteria of paragraph (b).

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—
(a) There is created a nonprofit entity to be known as the "Florida Small Employer Health Reinsurance Program."
(b)1. The program shall operate subject to the supervision and control of the board.
2. Effective upon this act becoming a law, the board shall consist of the director of the office or his or her designee, who shall serve as the chairperson, and 13 additional members who are representatives of carriers and insurance agents and are appointed by the director of the office and serve as follows:
a. Five members shall be representatives of health insurers licensed under chapter 624 or chapter 641. Two members shall be agents who are actively engaged in the sale of health insurance. Four members shall be employers or representatives of employers. One member shall be a person covered under an individual health insurance policy issued by a licensed insurer in this state. One member shall represent the Agency for Health Care Administration and shall be recommended by the Secretary of Health Care Administration.
b. A member appointed under this subparagraph shall serve a term of 4 years and shall continue in office until the member's successor takes office, except that, in order to provide for staggered terms, the director of the office shall designate two of the initial appointees under this subparagraph to serve terms of 2 years and shall designate three of the initial appointees under this subparagraph to serve terms of 3 years.
3. The director of the office may remove a member for cause.
4. Vacancies on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term.
(c)1. The board shall submit to the office a plan of operation to assure the fair, reasonable, and equitable administration of the program. The board may at any time submit to the office any amendments to the plan that the board finds to be necessary or suitable.
2. The office shall, after notice and hearing, approve the plan of operation if it determines that the plan submitted by the board is suitable to assure the fair, reasonable, and equitable administration of the program and provides for the sharing of program gains and losses equitably and proportionately in accordance with paragraph (j).
3. The plan of operation, or any amendment thereto, becomes effective upon written approval of the office.
(d) The plan of operation must, among other things:
1. Establish procedures for handling and accounting for program assets and moneys and for an annual fiscal reporting to the office.
2. Establish procedures for selecting an administering carrier and set forth the powers and duties of the administering carrier.
3. Establish procedures for reinsuring risks.
4. Establish procedures for collecting assessments from participating carriers to provide for claims reinsured by the program and for administrative expenses, other than amounts payable to the administrative carrier, incurred or estimated to be incurred during the period for which the assessment is made.
5. Provide for any additional matters at the discretion of the board.
(e) The board shall recommend to the office market conduct requirements and other requirements for carriers and agents, including requirements relating to:
1. Registration by each carrier with the office of its intention to be a small employer carrier under this section;
2. Publication by the office of a list of all small employer carriers, including a requirement applicable to agents and carriers that a health benefit plan may not be sold by a carrier that is not identified as a small employer carrier;

3. The availability of a broadly publicized, toll-free telephone number for access by small employers to information concerning this section;
4. Periodic reports by carriers and agents concerning health benefit plans issued; and
5. Methods concerning periodic demonstration by small employer carriers and agents that they are marketing or issuing health benefit plans to small employers.
(f) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to groups or individuals. In addition thereto, the program has specific authority to:
1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this act, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.
2. Sue or be sued, including taking any legal action necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any carrier.
3. Take any legal action necessary to avoid the payment of improper claims against the program.
4. Issue reinsurance policies, in accordance with the requirements of this act.
5. Establish rules, conditions, and procedures for reinsurance risks under the program participation.
6. Establish actuarial functions as appropriate for the operation of the program.
7. Assess participating carriers in accordance with paragraph (j), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.
8. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, and in any other function within the authority of the program.
9. Borrow money to effect the purposes of the program. Any notes or other evidences of indebtedness of the program which are not in default constitute legal investments for carriers and may be carried as admitted assets.
10. To the extent necessary, increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflation.
(g) A reinsuring carrier may reinsure with the program coverage of an eligible employee of a small employer, or any dependent of such an employee, subject to each of the following provisions:
1. Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 60 days after the commencement of the coverage of the small employer. A newly employed eligible employee or dependent of a small employer may be reinsured within 60 days after the commencement of his or her coverage.
2. A small employer carrier may reinsure an entire employer group within 60 days after the commencement of the group's coverage under the plan.
3. The program may not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year and the program shall reinsure the remainder.
4. The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban

Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the office approves a lower adjustment factor.
5. A small employer carrier may terminate reinsurance for all reinsured employees or dependents on any plan anniversary.
6. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 3., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 3. which may not be ceded to the program.
7. The board may consider adjustments to the premium rates charged for reinsurance by the program for carriers that use effective cost containment measures, including high-cost case management, as defined by the board.
8. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured business and nonreinsured business.
(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the office. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. The multiplying factors must be established as follows:
a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.
b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.
2. The board periodically shall review the methodology established, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates which shall be subject to the approval of the office.
(i) If a health benefit plan for a small employer issued in accordance with this subsection is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must be consistent with the requirements relating to premium rates set forth in this section.
(j)1. Before July 1 of each calendar year, the board shall determine and report to the office the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.
2. Any net loss for the year shall be recouped by assessment of the carriers, as follows:
a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. Except as provided in paragraph (m), risk-assuming carriers are

exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

b. The board shall equitably assess carriers for operating losses of the plan based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

c. Subject to the approval of the office, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

3. Before July 1 of each year, the board shall determine and file with the office an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the office within 180 days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the office within 180 days following the end of the applicable calendar year, the office may evaluate the operations of the program and implement such amendments to the plan of operation the office deems necessary to reduce future losses and assessments.

5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the term "future losses" includes reserves for incurred but not reported claims.

6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and other reports considered necessary by the board and filed by the carriers with the board.

7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.

8. A carrier may seek, from the office, a deferment, in whole or in part, from any assessment made by the board. The office may defer, in whole or in part, the assessment of a carrier if, in the opinion of the office, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in

whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.

(k) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, nor any other joint or collective action required by this act, may be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its carriers either jointly or separately.

(l) The board shall monitor compliance with this section, including the market conduct of small employer carriers, and shall report to the office any unfair trade practices and misleading or unfair conduct by a small employer carrier that has been reported to the board by agents, consumers, or any other person. The office shall investigate all reports and, upon a finding of noncompliance with this section or of unfair or misleading practices, shall take action against the small employer carrier as permitted under the insurance code or chapter 641. The board is not given investigatory or regulatory powers, but must forward all reports of cases or abuse or misrepresentation to the office.

(m) Notwithstanding paragraph (j), the administrative expenses of the program shall be recouped by assessment of risk-assuming carriers and reinsuring carriers and such amounts shall not be considered part of the operating losses of the plan for the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state during such calendar year.

(n) The board shall advise the office, the Agency for Health Care Administration, the department, other executive departments, and the Legislature on health insurance issues. Specifically, the board shall:

1. Provide a forum for stakeholders, consisting of insurers, employers, agents, consumers, and regulators, in the private health insurance market in this state.
2. Review and recommend strategies to improve the functioning of the health insurance markets in this state with a specific focus on market stability, access, and pricing.
3. Make recommendations to the office for legislation addressing health insurance market issues and provide comments on health insurance legislation proposed by the office.
4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed to address health insurance market issues, and to provide comments on health insurance legislation proposed by the office.
5. Issue a report to the office on the state of the health insurance market by September 1 each year. The report shall include recommendations for changes in the health insurance market, results from implementation of previous recommendations, and information on health insurance markets.

(16) RESTRICTIONS ON COVERAGE.—

(a) A plan under which coverage is purchased in whole or in part with any state or federal funds through an exchange created pursuant to the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, may not provide coverage for an abortion, as defined in s. 390.011(1), except if the pregnancy is the result of an act of rape or incest, or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of

death unless an abortion is performed. Coverage is deemed to be purchased with state or federal funds if any tax credit or cost-sharing credit is applied toward the plan.
(b) This subsection does not prohibit a plan from providing any person or entity with separate coverage for an abortion if such coverage is not purchased in whole or in part with state or federal funds.
(c) As used in this section, the term "state" means this state or any political subdivision of the state.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the

department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to

by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

690-191

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

641.31 Health maintenance contracts.—
(1) Any entity issued a certificate and otherwise in compliance with this part may enter into contracts in this state to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or a prepaid aggregate fixed sum. Each subscriber shall be given a copy of the applicable health maintenance contract, certificate, or member handbook. Whichever document is provided to a subscriber shall contain all of the provisions and disclosures required by this section.
(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. The commission, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.
(3)(a) If a health maintenance organization desires to amend any contract with its subscribers or any certificate or member handbook, or desires to change any basic health maintenance contract, certificate, grievance procedure, or member handbook form, or application form where written application is required and is to be made a part of the contract, or printed amendment, addendum, rider, or endorsement form or form of renewal certificate, it may do so, upon filing with the office the proposed change or amendment. Any proposed change shall be effective immediately, subject to disapproval by the office. Following receipt of notice of such disapproval or withdrawal of approval, no health maintenance organization shall issue or use any form disapproved by the office or as to which the office has withdrawn approval.
(b) Any change in the rate is subject to paragraph (d) and requires at least 30 days' advance written notice to the subscriber. In the case of a group member, there may be a contractual agreement with the health maintenance organization to have the employer provide the required notice to the individual members of the group.
(c) The office shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, if the form:
1. Is in any respect in violation of, or does not comply with, any provision of this part or rule adopted thereunder.
2. Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.
3. Has any title, heading, or other indication of its provisions which is misleading.
4. Is printed or otherwise reproduced in such a manner as to render any material provision of the form substantially illegible.
5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.
6. Excludes coverage for human immunodeficiency virus infection or acquired immune deficiency syndrome or contains limitations in the benefits payable, or in the terms or conditions of such contract, for human immunodeficiency virus infection or acquired immune

deficiency syndrome which are different than those which apply to any other sickness or medical condition.
(d) Any change in rates charged for the contract must be filed with the office not less than 30 days in advance of the effective date. At the expiration of such 30 days, the rate filing shall be deemed approved unless prior to such time the filing has been affirmatively approved or disapproved by order of the office. The approval of the filing by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such filing, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such filing shall be deemed approved. This paragraph does not apply to group health contracts effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claims costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.
(e) It is not the intent of this subsection to restrict unduly the right to modify rates in the exercise of reasonable business judgment.
(4) Every health maintenance contract, certificate, or member handbook shall clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement of any limitations on the services or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract or by any insurer or entity which is underwriting any of the services offered by the health maintenance organization. The contract, certificate, or member handbook shall also state where and in what manner the comprehensive health care services may be obtained.
(5) Every subscriber shall receive a clear and understandable description of the method of the health maintenance organization for resolving subscriber grievances, and the method shall be set forth in the contract, certificate, and member handbook. The organization shall also furnish, at the time of initial enrollment and when necessary due to substantial changes to the grievance process a separate and additional communication prepared or approved by the office notifying the contract holder of a group contract or subscriber of an individual contract of their rights and responsibilities under the grievance process.
(6) The rate of payment for a health maintenance contract shall be a part of the contract and shall be stated in individual contracts issued to subscribers.
(7) A health maintenance organization is entitled to coordinate benefits on the same basis as an insurer under s. 627.4235.
(8) A health maintenance organization providing medical benefits or payments to a subscriber who suffers injury, disease, or illness by virtue of the negligent act or omission of a third party is entitled to reimbursement from the subscriber in accordance with s. 768.76(4).
(9) All health maintenance contracts that provide coverage, benefits, or services for a member of the family of the subscriber must, as to such family member's coverage, benefits, or services, provide also that the coverage, benefits, or services applicable for children must be provided with respect to a newborn child of the subscriber, or covered family member of the subscriber, from the moment of birth. However, with respect to a newborn child of a covered family member other than the spouse of the insured or subscriber, the coverage for the newborn child terminates 18 months after the birth of the newborn child. The coverage, benefits, or services for newborn children must consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest appropriate facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the

attending physician as medically necessary to protect the health and safety of the newborn child.

(a) A contract may require the subscriber to notify the plan of the birth of a child within a time period, as specified in the contract, of not less than 30 days after the birth, or a contract may require the preenrollment of a newborn prior to birth. However, if timely notice is given, a plan may not charge an additional premium for additional coverage of the newborn child for not less than 30 days after the birth of the child. If timely notice is not given, the plan may charge an additional premium from the date of birth. If notice is given within 60 days of the birth of the child, the contract may not deny coverage of the child due to failure of the subscriber to timely notify the plan of the birth of the child or to preenroll the child.

(b) If the contract does not require the subscriber to notify the plan of the birth of a child within a specified time period, the plan may not deny coverage of the child nor may it retroactively charge the subscriber an additional premium for the child; however, the contract may prospectively charge the member an additional premium for the child if the plan provides at least 45 days' notice of the additional charge.

(10) No alteration of any written application for any health maintenance contract shall be made by any person other than the applicant without his or her written consent, except that insertions may be made by the health maintenance organization, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(11) No contract shall contain any waiver of rights or benefits provided to or available to subscribers under the provisions of any law or rule applicable to health maintenance organizations.

(12) Each health maintenance contract, certificate, or member handbook shall state that emergency services and care shall be provided to subscribers in emergency situations not permitting treatment through the health maintenance organization's providers, without prior notification to and approval of the organization. Not less than 75 percent of the reasonable charges for covered services and supplies shall be paid by the organization, up to the subscriber contract benefit limits. Payment also may be subject to additional applicable copayment provisions, not to exceed $100 per claim. The health maintenance contract, certificate, or member handbook shall contain the definitions of "emergency services and care" and "emergency medical condition" as specified in s. 641.19(6) and (7), shall describe procedures for determination by the health maintenance organization of whether the services qualify for reimbursement as emergency services and care, and shall contain specific examples of what does constitute an emergency. In providing for emergency services and care as a covered service, a health maintenance organization shall be governed by s. 641.513.

(13) In addition to the requirements of this section, with respect to a person who is entitled to have payments for health care costs made under Medicare, Title XVIII of the Social Security Act ("Medicare"), parts A and/or B:

(a) The health maintenance organization shall mail or deliver notification to the Medicare beneficiary of the date of enrollment in the health maintenance organization within 10 days after receiving notification of enrollment approval from the United States Department of Health and Human Services, Health Care Financing Administration. When a Medicare beneficiary who is a subscriber of the health maintenance organization requests disenrollment from the organization, the organization shall mail or deliver to the beneficiary notice of the effective date of the disenrollment within 10 days after receipt of the written disenrollment request. The health maintenance organization shall forward the disenrollment request to the United States Department of Health and Human Services, Health Care Financing Administration, in a timely manner so as to effectuate the next available disenrollment date, as prescribed by such federal agency.

(b) The health maintenance contract, certificate, or member handbook shall be delivered to the subscriber no later than the earlier of 10 working days after the health maintenance organization and the Health Care Financing Administration of the United States Department of Health and Human Services approve the subscriber's enrollment application or the effective date of coverage of the subscriber under the health maintenance contract. However, if notice from the Health Care Financing Administration of its approval of the subscriber's enrollment application is received by the health maintenance organization after the effective coverage date prescribed by the Health Care Financing Administration, the health maintenance organization shall deliver the contract, certificate, or member handbook to the subscriber within 10 days after receiving such notice. When a Medicare recipient is enrolled in a health maintenance organization program, the contract, certificate, or member handbook shall be accompanied by a health maintenance organization identification sticker with instruction to the Medicare beneficiary to place the sticker on the Medicare identification card.

(14) Whenever a subscriber of a health maintenance organization is also a Medicaid recipient, the health maintenance organization's coverage shall be primary to the recipient's Medicaid benefits and the organization shall be a third party subject to the provisions of s. 409.910(4).

(15)(a) All health maintenance contracts, certificates, and member handbooks shall contain the following provision:

"Grace Period: This contract has a (insert a number not less than 10) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the following grace period. During the grace period, the contract will stay in force."

(b) The required provision of paragraph (a) shall not apply to certificates or member handbooks delivered to individual subscribers under a group health maintenance contract when the employer or other person who will hold the contract on behalf of the subscriber group pays the entire premium for the individual subscribers. However, such required provision shall apply to the group health maintenance contract.

(16) The contracts must clearly disclose the intent of the health maintenance organization as to the applicability or nonapplicability of coverage to preexisting conditions. If coverage of the contract is not to be applicable to preexisting conditions, the contract shall specify, in substance, that coverage pertains solely to accidental bodily injuries resulting from accidents occurring after the effective date of coverage and that sicknesses are limited to those which first manifest themselves subsequent to the effective date of coverage.

(17) All health maintenance contracts that provide coverage for a member of the family of the subscriber, shall, as to such family member's coverage, provide that coverage, benefits, or services applicable for children shall be provided with respect to an adopted child of the subscriber, which child is placed in compliance with chapter 63, from the moment of placement in the residence of the subscriber. Such contracts may not exclude coverage for any preexisting condition of the child. In the case of a newborn child, coverage shall begin from the moment of birth if a written agreement to adopt such child has been entered into by the subscriber prior to the birth of the child, whether or not such agreement is enforceable. However, coverage for such child shall not be required in the event that the child is not ultimately placed in the residence of the subscriber in compliance with chapter 63.

(18)(a) Health maintenance contracts that provide coverage, benefits, or services for maternity care must provide, as an option to the subscriber, the services of nurse-midwives and midwives licensed pursuant to chapter 467, and the services of birth centers licensed pursuant to ss. 383.30-383.335, if such services are available within the service area.

(b) Any health maintenance contract that provides maternity or newborn coverage may not limit coverage for the length of a maternity or newborn stay in a hospital or for followup

care outside of a hospital to any time period that is less than that determined to be medically necessary, in accordance with prevailing medical standards and consistent with guidelines for perinatal care of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists, by the treating obstetrical care provider or the pediatric care provider.

(c) This section does not affect any agreement between a health maintenance organization and a hospital or other health care provider with respect to reimbursement for health care services provided, rate negotiations with providers, or capitation of providers, and this section does not prohibit appropriate utilization review or case management by a health maintenance organization.

(d) Any health maintenance contract that provides coverage, benefits, or services for maternity or newborn care must provide coverage for postdelivery care for a mother and her newborn infant. The postdelivery care must include a postpartum assessment and newborn assessment and may be provided at the hospital, at the attending physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. The services must include physical assessment of the newborn and mother, and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards.

(e) A health maintenance organization subject to paragraph (b) shall communicate active case questions and concerns regarding postdelivery care directly to the treating physician or hospital in written form, in addition to other forms of communication. Such organization shall also use a process that includes a written protocol for utilization review and quality assurance.

(f) Any health maintenance organization subject to paragraph (b) may not:

1. Deny to a mother or her newborn infant eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the contract for the purpose of avoiding the requirements of this section.
2. Provide monetary payments or rebates to a mother to encourage the mother to accept less than the minimum protections available under this section.
3. Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to an individual participant or beneficiary in accordance with this section.
4. Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.
5. Subject to paragraph (i), restrict benefits for any portion of a period within a hospital length of stay required under paragraph (b) in a manner that is less favorable than the benefits provided for any preceding portion of such stay.

(g) This subsection does not require a mother who is a participant or beneficiary to:

1. Give birth in a hospital.
2. Stay in the hospital for a fixed period of time following the birth of her infant.

(h) This subsection does not apply with respect to any coverage offered by a health maintenance organization that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn infant.

(i) This subsection does not prevent a health maintenance organization from imposing deductibles, coinsurance, or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn infant under the contract or under health insurance coverage offered in connection with a group health plan, except that such coinsurance or other cost sharing for any portion of a period within a hospital length of stay required under paragraph (b) may not be greater than such coinsurance or cost sharing for any preceding portion of such stay.

(19) Notwithstanding any other provision of law, health maintenance policies or contracts which provide coverage, benefits, or services as described in s. 463.002(7), shall offer to the subscriber the services of an optometrist licensed pursuant to chapter 463.
(20) Notwithstanding any other provision of law, health maintenance policies or contracts which provide coverage, benefits, or services which are performed by physicians who are ophthalmologists, licensed pursuant to chapter 458 or chapter 459, shall offer the subscriber the services of an ophthalmologist. For purposes of this subsection, ophthalmologists are physicians specializing in the diagnosis and treatment of diseases and injuries of the eye.
(21) Notwithstanding any other provision of law, health maintenance policies or contracts which provide anesthesia coverage, benefits, or services shall offer to the subscriber, if requested and available, the services of a certified registered nurse anesthetist licensed pursuant to part I of chapter 464.
(22) Each health maintenance organization that offers a group plan within this state must have at least one open enrollment period of not less than 30 days every 18 months. Such open enrollment periods are required for as long as the group exists unless the health maintenance organization and the employer mutually agree to a shorter period of time than 18 months.
(23) The contract shall include the following provision:

"Time limit on certain defenses: Relative to a misstatement in the application, after 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the 2-year period."

(24) Each health maintenance organization that provides for inpatient and outpatient services by allopathic hospitals shall provide as an option of the subscriber similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available in the same service area of the HMO and the osteopathic hospital agrees to provide the services as specified herein. As a condition precedent to providing osteopathic inpatient and outpatient services through an osteopathic hospital that has not entered into a written contract with the HMO, the HMO may require the subscriber or any other person receiving osteopathic services to release the HMO from any liability arising from any act of omission or commission constituting malpractice in the delivery of osteopathic care from that hospital. The osteopathic hospital providing the inpatient and outpatient services for the HMO shall charge rates that do not exceed the osteopathic hospital's usual and customary rates less the average discount provided by allopathic hospitals providing the HMO services in the same service area of the HMO.
(25) If a subscriber is a resident of a continuing care facility certified under chapter 651 or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, the subscriber's primary care physician must refer the subscriber to that facility's skilled nursing unit or assisted living facility if requested by the subscriber and agreed to by the facility; if the primary care physician finds that such care is medically necessary; if the facility agrees to be reimbursed at the health maintenance organization's contract rate negotiated with similar providers for the same services and supplies; and if the facility meets all guidelines established by the health maintenance organization related to quality of care, utilization, referral authorization, risk assumption, use of the health maintenance organization's network, and other criteria applicable to providers under contract for the same services and supplies. If a health maintenance organization enrolls a new subscriber who already resides in a continuing care facility or a retirement facility as described in this subsection, the health maintenance organization must provide in writing a disclosure of the subscriber's rights under this subsection. If a subscriber's request to be referred to the skilled nursing unit or assisted living facility that is part of the subscriber's

place of residence is not honored, the subscriber may use the grievance process provided in s. 641.511.
(26)(a) Each health maintenance organization and prepaid health plan shall provide coverage for all medically appropriate and necessary equipment, supplies, and services used to treat diabetes, including outpatient self-management training and educational services, if the patient's primary care physician, or the physician to whom the patient has been referred who specializes in treating diabetes, certifies that the equipment, supplies, or services are necessary.
(b) The contract may require that diabetes outpatient self-management training and educational services be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist under contract with or designated by the health maintenance organization or prepaid health plan.
(c) The Agency for Health Care Administration shall adopt standards for outpatient self-management training and educational services, taking into consideration standards approved by the American Diabetes Association.
(27) Any health maintenance contract that covers a resident of this state and that is issued, amended, delivered, or renewed in this state after October 1, 1996, must provide coverage for the medically necessary diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis. This subsection shall not apply to the state employee health insurance program.
(28) A health maintenance organization may not discriminate against or fail to contract with a hospital, based solely on the fact that the hospital's medical staff is comprised of physicians licensed under chapter 459. Nothing in this subsection shall mandate that a health maintenance organization contract with a hospital.
(29) If a health maintenance contract provides that coverage of a dependent child of the subscriber terminates upon attainment of the limiting age for dependent children which is specified in the contract, the contract must also provide in substance that attainment of the limiting age does not terminate the coverage of the child while the child continues to be both:
(a) Incapable of self-sustaining employment by reason of an intellectual or physical disability.
(b) Chiefly dependent upon the employee or member for support and maintenance.

If the claim is denied under a contract for the stated reason that the child has attained the limiting age for dependent children specified in the contract, the notice or denial must state that the subscriber has the burden of establishing that the child continues to meet the criteria specified in this subsection.

(30)(a) All health maintenance contracts which provide coverage, benefits, or services for a member of the family of the subscriber must, as to such family member's coverage, benefits, or services, also provide that the benefits applicable for children include coverage for child health supervision services from the moment of birth to age 16 years.
(b) As used in this subsection, the term "child health supervision services" means physician-delivered or physician-supervised services that include, at a minimum, services delivered at the intervals and scope stated in this subsection.
1. Child health supervision services must include periodic visits which shall include a history, a physical examination, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

2. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this subsection.

(31)(a) Health maintenance contracts that provide coverage, benefits, or services for breast cancer treatment may not limit inpatient hospital coverage for mastectomies to any period that is less than that determined by the treating physician under contract with the health maintenance organization to be medically necessary in accordance with prevailing medical standards and after consultation with the covered patient. Such contract must also provide coverage for outpatient postsurgical followup care in keeping with prevailing medical standards by a licensed health care professional under contract with the health maintenance organization qualified to provide postsurgical mastectomy care. The treating physician under contract with the health maintenance organization, after consultation with the covered patient, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the hospital, treating physician's office, outpatient center, or home of the covered patient.

(b) A health maintenance organization subject to this subsection may not:

1. Deny to a covered person eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the contract for the purpose of avoiding the requirements of this subsection;

2. Provide monetary payments or rebates to a covered patient to accept less than the minimum protections available under this subsection;

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to a covered patient under this subsection;

4. Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to a covered patient in a manner inconsistent with this subsection; or

5. Subject to the other provisions of this subsection, restrict benefits for any portion of a period within a hospital length of stay or outpatient care as required by this subsection in a manner that is less than favorable than the benefits provided for any preceding portion of such stay.

(c)1. This subsection does not require a covered patient to have the mastectomy in the hospital or stay in the hospital for a fixed period of time following the mastectomy.

2. This subsection does not prevent a contract from imposing deductibles, coinsurance, or other cost sharing in relation to benefits pursuant to this subsection, except that such cost sharing shall not exceed cost sharing with other benefits.

(d) Except as provided in paragraph (b), this subsection does not affect any agreement between a health maintenance organization and a hospital or other health care provider with respect to reimbursement for health care services provided, rate negotiations with providers, or capitation of providers, and does not prohibit appropriate utilization review or case management by the health maintenance organization.

(e) As used in this subsection, the term "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(32) A health maintenance contract that provides coverage for mastectomies must also provide coverage for prosthetic devices and breast reconstructive surgery incident to the mastectomy. As used in this subsection, the term "breast reconstructive surgery" means surgery to reestablish symmetry between the two breasts. Such surgery must be in a manner chosen by the treating physician under contract with the health maintenance organization, consistent with prevailing medical standards, and in consultation with the patient. The health maintenance organization may charge an appropriate additional premium for the coverage required by this subsection. The coverage for prosthetic devices and breast reconstructive surgery shall be subject to any deductible and coinsurance conditions.

(33) Notwithstanding any provision of this section to the contrary, a health maintenance organization which offers dermatological services shall provide direct patient access, for

office visits and minor procedures and testing, to a dermatologist who is under contract with the health maintenance organization. The term "direct patient access" means the ability of a subscriber to obtain such services without a referral or other authorization before receiving services. The health maintenance organization shall, by July 1, 1997, develop criteria for compliance with the provisions of this subsection which do not impede or inhibit access to dermatological services for policyholders of the health maintenance organization. The criteria may include a maximum of five office visits to a dermatologist without prior authorization for a dermatologic problem within a 12-month period.

(34) For purposes of this subsection, dental treatment or surgery shall be considered necessary when the dental condition is likely to result in a medical condition if left untreated. Any health maintenance organization contract which provides coverage for general anesthesia and hospitalization services to a covered person shall not preclude such coverage in assuring the safe delivery of necessary dental care provided to a covered person who:

(a) Is under 8 years of age and is determined by a licensed dentist, and the child's physician licensed under chapter 458 or chapter 459, to require necessary dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or

(b) Has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

As provided herein, all terms and conditions of the covered person's health maintenance organization contract shall apply to such services, and this section does not require coverage for the diagnosis or treatment of dental disease. A health maintenance organization may require prior authorization for general anesthesia and hospital services required under this section in the same manner the organization requires prior authorization for hospitalization for other covered services. This subsection shall not apply to Medicare supplement, long-term care, disability, limited benefit, accident only, or specified disease policies.

(35) A health maintenance contract that covers a child under the age of 18 must provide coverage for treatment of cleft lip and cleft palate for the child. The coverage must include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the primary care physician or physician to whom the child is referred and such physician certifies that such services are medically necessary and consequent to treatment of the cleft lip or cleft palate. The coverage required by this section is subject to terms and conditions applicable to other benefits.

(36) A health maintenance organization may increase the copayment for any benefit, or delete, amend, or limit any of the benefits to which a subscriber is entitled under the group contract only, upon written notice to the contract holder at least 45 days in advance of the time of coverage renewal. The health maintenance organization may amend the contract with the contract holder, with such amendment to be effective immediately at the time of coverage renewal. The written notice to the contract holder shall specifically identify any deletions, amendments, or limitations to any of the benefits provided in the group contract during the current contract period which will be included in the group contract upon renewal. This subsection does not apply to any increases in benefits. The 45-day notice requirement shall not apply if benefits are amended, deleted, or limited at the request of the contract holder.

(37) All health maintenance contracts that provide coverage for massage must also cover the services of persons licensed to practice massage pursuant to chapter 480 if the massage is prescribed by a contracted physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 as medically necessary and the prescription specifies the number of

treatments. Such massage services are subject to the same terms, conditions, and limitations as those of other covered services.

(38)(a) Notwithstanding any other provision of this part, a health maintenance organization that meets the requirements of paragraph (b) may, through a point-of-service rider to its contract providing comprehensive health care services, include a point-of-service benefit. Under such a rider, a subscriber or other covered person of the health maintenance organization may choose, at the time of covered service, a provider with whom the health maintenance organization does not have a health maintenance organization provider contract. The rider may not require a referral from the health maintenance organization for the point-of-service benefits.

(b) A health maintenance organization offering a point-of-service rider under this subsection must have a valid certificate of authority issued under the provisions of the chapter, must have been licensed under this chapter for a minimum of 3 years, and must at all times that it has riders in effect maintain a minimum surplus of $5 million. A health maintenance organization offering a point-of-service rider to its contract providing comprehensive health care services may offer the rider to employers who have employees living and working outside the health maintenance organization's approved geographic service area without having to obtain a health care provider certificate, as long as the master group contract is issued to an employer that maintains its primary place of business within the health maintenance organization's approved service area. Any member or subscriber that lives and works outside the health maintenance organization's service area and elects coverage under the health maintenance organization's point-of-service rider must provide a statement to the health maintenance organization that indicates the member or subscriber understands the limitations of his or her policy and that only those benefits under the point-of-service rider will be covered when services are provided outside the service area.

(c) Premiums paid in for the point-of-service riders may not exceed 15 percent of total premiums for all health plan products sold by the health maintenance organization offering the rider. If the premiums paid for point-of-service riders exceed 15 percent, the health maintenance organization must notify the office and, once this fact is known, must immediately cease offering such a rider until it is in compliance with the rider premium cap.

(d) Notwithstanding the limitations of deductibles and copayment provisions in this part, a point-of-service rider may require the subscriber to pay a reasonable copayment for each visit for services provided by a noncontracted provider chosen at the time of the service. The copayment by the subscriber may either be a specific dollar amount or a percentage of the reimbursable provider charges covered by the contract and must be paid by the subscriber to the noncontracted provider upon receipt of covered services. The point-of-service rider may require that a reasonable annual deductible for the expenses associated with the point-of-service rider be met and may include a lifetime maximum benefit amount. The rider must include the language required by s. 627.6044 and must comply with copayment limits described in s. 627.6471. Section 641.3154 does not apply to a point-of-service rider authorized under this subsection.

(e) The point-of-service rider must contain provisions that comply with s. 627.6044.

(f) The term "point of service" may not be used by a health maintenance organization except with riders permitted under this section or with forms approved by the office in which a point-of-service product is offered with an indemnity carrier.

(g) A point-of-service rider must be filed and approved under ss. 627.410 and 627.411.

(39) A health maintenance organization contract may not prohibit or restrict a subscriber from receiving inpatient services in a contracted hospital from a contracted primary care or admitting physician if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

(40)(a) Any group rate, rating schedule, or rating manual for a health maintenance organization policy, which provides creditable coverage as defined in s. 627.6562(3), filed

with the office shall provide for an appropriate rebate of premiums paid in the last policy year, contract year, or calendar year when the majority of members of a health plan are enrolled in and have maintained participation in any health wellness, maintenance, or improvement program offered by the group contract holder. The group must provide evidence of demonstrative maintenance or improvement of his or her health status as determined by assessments of agreed-upon health status indicators between the group and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. Any rebate provided by the health maintenance organization is presumed to be appropriate unless credible data demonstrates otherwise, or unless the rebate program requires the insured to incur costs to qualify for the rebate which equals or exceeds the value of the rebate but the rebate may not exceed 10 percent of paid premiums.

(b) The premium rebate authorized by this section shall be effective for a subscriber on an annual basis, unless the number of participating members on the contract renewal anniversary becomes fewer than the majority of the members eligible for participation in the wellness program.

(c) A health maintenance organization that issues individual contracts may offer a premium rebate, as provided under this section, for a healthy lifestyle program.

(41) All health maintenance contracts providing coverage for a member of the subscriber's family must comply with the provisions of s. 627.6562.

(42) The contract, certificate, or member handbook must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization offering the contract or name of the organization administering the contract, whichever applies.

(b) The name of the subscriber.

(c) A statement that the health plan is a health maintenance organization. Only a health plan with a certificate of authority issued under this chapter may be identified as a health maintenance organization.

(d) The member identification number, contract number, and group number, if applicable.

(e) A contact phone number or electronic address for authorizations and admission certifications.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the contract may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

(43) Whenever, in any health maintenance organization claim form, a subscriber specifically authorizes payment of benefits directly to any contracted hospital, ambulance provider, physician, or dentist, the health maintenance organization shall make such payment to the designated provider of such services if any benefits are due to the subscriber under the terms of the agreement between the subscriber and the health maintenance organization. The health maintenance organization contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, ambulance provider, physician, or dentist for covered services provided, for services provided pursuant to s. 395.1041, and for ambulance transport and treatment

provided pursuant to part III of chapter 401. The attestation of assignment of benefits may be in written or electronic form. Payment to the provider from the health maintenance organization may not be more than the amount that the insurer would otherwise have paid without the assignment. This subsection does not affect the applicability of ss. 641.3154 and 641.513 with respect to services provided and payment for such services provided pursuant to the subsection.

641.36 Adoption of rules; penalty for violation.—The commission shall adopt rules necessary to carry out the provisions of this part. The office shall collect and make available all health maintenance organization rules adopted by the commission. Any violation of a rule adopted under this section shall subject the violating entity to the provisions of s. 641.23.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other

section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit

committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

628.4615 Specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.—
(1) For the purposes of this section, the term "specialty insurer" means any person holding a license or certificate of authority as:
(a) A motor vehicle service agreement company authorized to issue motor vehicle service agreements as those terms are defined in s. 634.011;
(b) A home warranty association authorized to issue "home warranties" as those terms are defined in s. 634.301;
(c) A service warranty association authorized to issue "service warranties" as those terms are defined in s. 634.401(13) and (14);
(d) A prepaid limited health service organization authorized to issue prepaid limited health service contracts, as those terms are defined in chapter 636;
(e) An authorized health maintenance organization operating pursuant to s. 641.21;
(f) An authorized prepaid health clinic operating pursuant to s. 641.405;
(g) A legal expense insurance corporation authorized to engage in a legal expense insurance business pursuant to s. 642.021;
(h) A provider that is licensed to operate a facility that undertakes to provide continuing care as those terms are defined in s. 651.011;
(i) A multiple-employer welfare arrangement operating pursuant to ss. 624.436-624.446;
(j) A premium finance company authorized to finance insurance premiums pursuant to s. 627.828; or
(k) A corporation authorized to accept donor annuity agreements pursuant to s. 627.481.
(2) A person may not, individually or in conjunction with any affiliated person of such person, directly or indirectly, conclude a tender offer or exchange offer for, enter into any agreement to exchange securities for, or otherwise finally acquire, 10 percent or more of the outstanding voting securities of a specialty insurer which is a stock corporation or of a controlling company of a specialty insurer which is a stock corporation; or conclude an acquisition of, or otherwise finally acquire, 10 percent or more of the ownership interest of a specialty insurer which is not a stock corporation or of a controlling company of a specialty insurer which is not a stock corporation, unless:
(a) The person or affiliated person has filed with the office and sent by registered mail to the principal office of the specialty insurer and controlling company a letter of notification regarding the transaction or proposed transaction no later than 5 days after any form of tender offer or exchange offer is proposed, or no later than 5 days after the acquisition of the securities or ownership interest if no tender offer or exchange offer is involved. The

notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;
(b) The person or affiliated person has filed with the office an application signed under oath and prepared on forms prescribed by the commission which contains the information specified in subsection (4). The application must be completed and filed within 30 days after any form of tender offer or exchange offer is proposed, or after the acquisition of the securities if no tender offer or exchange offer is involved; and
(c) The office has approved the tender offer or exchange offer, or acquisition if no tender offer or exchange offer is involved.
(3) This section does not apply to any acquisition of voting securities or ownership interest of a specialty insurer or of a controlling company by any person who, on July 9, 1986, is the owner of a majority of such voting securities or ownership interest or who, on or after July 9, 1986, becomes the owner of a majority of such voting securities or ownership interest with the approval of the office under this section. The person or affiliated person filing the required notice in paragraph (2)(a) may request the office to waive the requirements of paragraph (2)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the specialty insurer. The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the specialty insurer.
(4) The application to be filed with the office and furnished to the specialty insurer and controlling company shall contain the following information and any additional information as the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the insureds of the insurer and of the public:
(a)1. The identity of, and the background information specified in subsection (5) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and,
2. If the acquisition is to be made by, or on behalf of, a person other than a natural person and as to any person who controls, either directly or indirectly, such other person, the identity of, and the background information specified in subsection (5) on:
a. Each director, officer, or trustee, if a corporation, or
b. Each partner, owner, manager, or joint venturer, or other person performing duties similar to those of persons in the aforementioned positions, if not a corporation,

for the person.

(b) The source and amount of the funds or other consideration used, or to be used, in making the acquisition.
(c) Any plans or proposals which such persons may have made to liquidate the specialty insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management; and any plans or proposals which such persons may have made to liquidate any controlling company of the specialty insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management.
(d) The nature and the extent of the controlling interest which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the controlling interest is to be acquired of a specialty insurer or controlling company which is not a stock corporation.
(e) The number of shares or other securities which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the securities are to be acquired.

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

(5)(a) The information as to the background and identity of each natural person, which information is required to be furnished pursuant to paragraph (4)(a), shall include:

1. The natural person's occupations, positions of employment, and offices held during the past 10 years.
2. The principal business and address of any business, corporation, or organization in which each such office of the natural person was held, or in which each such occupation or position of employment was carried on.
3. Whether the natural person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.
4. Whether the natural person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.
5. Whether, during the 10-year period, the natural person has been the subject of any proceeding under the federal [1]Bankruptcy Act; or whether, during the 10-year period, any person or other business or organization in which the natural person was a director, officer, trustee, partner, owner, manager, or other official has been subject to any such proceeding, either during the time in which the natural person was a director, officer, or trustee, if a corporation, or a partner, owner, manager, joint venturer, or other official, if not a corporation, or within 12 months thereafter.
6. Whether, during the 10-year period, the natural person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law regulating the business of insurance, securities, or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities, or banking, together with details as to any such event.
7. Fingerprints of each person referred to in subsection (4).

(b) Any person filing the statement required by this section shall give all required information that is within the knowledge of:

1. The directors, officers, or trustees, if a corporation, or
2. The partners, owners, managers, or joint venturers, or others performing functions similar to those of a director, officer, or trustee, if not a corporation,

of the person making the filing and of any person controlling either directly or indirectly such person. If any material change occurs in the facts set forth in the application filed with the office pursuant to this section, an amendment setting forth such changes shall be filed immediately with the office, and a copy of the amendment shall be sent by registered mail to the principal office of the specialty insurer and to the principal office of the controlling company.

(6)(a) The acquisition application shall be reviewed in accordance with chapter 120. The office may on its own initiate, or, if requested to do so in writing by a substantially affected person, shall conduct, a proceeding to consider the appropriateness of the proposed filing. Time periods for purposes of chapter 120 shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10 days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time it finds an immediate danger to the public

health, safety, and welfare of the insureds exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition disapproved and any further steps to conclude the acquisition ceased.

(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the specialty insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the specialty insurer unless advance written notice of the change in management is furnished to the office. A material change in the operation of the specialty insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the specialty insurer. A material change in the management of the specialty insurer is any change in management involving officers or directors of the specialty insurer or any person of the specialty insurer or controlling company having authority to dispose of or obligate 5 percent or more of the specialty insurer's capital or surplus. The office shall approve a material change in operations if it finds the applicable provisions of subsection (8) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (8) have not been met and in such case the specialty insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(7) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:

(a) Willfully violates this section;

(b) In violation of an order of the office issued pursuant to subsection (11), fails to divest himself or herself of any stock or ownership interest obtained in violation of this section or fails to divest himself or herself of any direct or indirect control of such stock or ownership interest, within 25 days after such order; or

(c) In violation of an order issued by the office pursuant to subsection (11), acquires an additional stock or ownership interest in a specialty insurer or controlling company or direct or indirect control of such stock or ownership interest, without complying with this section.

(8) The person or persons filing the application required by subsection (2) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed application if no proceeding is conducted, that:

(a) Upon completion of the acquisition, the specialty insurer will be able to satisfy the requirements for the issuance of a license or certificate to write the line of insurance for which it is presently licensed or certificated.

(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the specialty insurer or prejudice the interests of its insureds or the public.

(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:

1. To liquidate the specialty insurer, sell its assets, or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management, or

2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the specialty insurer,

is fair and free of prejudice to the insureds of the specialty insurer or to the public.

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the specialty insurer indicate that the acquisition is in the best interest of the insureds of the insurer and in the public interest.
(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the insureds of the specialty insurer and in the public interest to permit such persons to exercise control over the specialty insurer.
(f) The directors and officers, if such specialty insurer or controlling company is a stock corporation, or the trustees, partners, owners, managers, or joint venturers or other persons performing duties similar to those of persons in the aforementioned positions, if such specialty insurer or controlling company is not a stock corporation, to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation.
(g) The management of the specialty insurer after the acquisition will be competent and trustworthy, and will possess sufficient managerial experience so as to make the proposed operation of the specialty insurer not hazardous to the insurance-buying public.
(h) The management of the specialty insurer after the acquisition shall not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto.
(i) The acquisition is not likely to be hazardous or prejudicial to the insureds of the insurer or to the public.
(j) The effect of the acquisition would not substantially lessen competition in the line of insurance for which the specialty insurer is licensed or certified in this state or would not tend to create a monopoly therein.
(9) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition contrary to the provisions of this section is void. Upon the petition of the specialty insurer or the controlling company, the circuit court for the county in which the principal office of the specialty insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the provisions of this section. There shall be a private right of action in favor of the specialty insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the specialty insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by the specialty insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of an application pursuant to this section, or who files such an application, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.
(10) Any approval by the office under this section does not constitute a recommendation by the office of the tender offer or exchange offer, or acquisition, if no tender offer or exchange offer is involved. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.
(11) If the office determines that any person or any affiliated person of such person has acquired 10 percent or more of the outstanding voting securities of a specialty insurer or controlling company which is a stock corporation, or 10 percent or more of the ownership interest of a specialty insurer or controlling company which is not a stock corporation,

without complying with the provisions of this section, the office may order that the person and any affiliated person of such person cease acquisition of the specialty insurer or controlling company and, if appropriate, divest itself of any stock or ownership interest acquired in violation of this section.

(12)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any specialty insurer or controlling company acquired in violation of this section.

(b) If any specialty insurer is subject to suspension or revocation pursuant to paragraph (a), the specialty insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its insureds, creditors, or stockholders or to the public.

(13)(a) For the purpose of this section, the term "acquisition" includes:

1. A tender offer or exchange offer for securities, assets, or other ownership interest;
2. An agreement to exchange securities for other securities, assets, or other ownership interest;
3. A merger of a person or affiliated person into a specialty insurer or a merger of any person with a specialty insurer;
4. A consolidation; or
5. Any other form of change of control

whereby any person or affiliated person acquires or attempts to acquire, directly or indirectly, 10 percent or more of the ownership interest or assets of a specialty insurer or of a controlling company. However, in the case of a health maintenance organization organized as a for-profit corporation, the provisions of s. 628.451 shall govern with respect to any merger or consolidation, and, in the case of a health maintenance organization organized as a not-for-profit corporation, the provisions of s. 628.471 shall govern with respect to any merger or consolidation.

(b) For the purpose of this section, the term "affiliated person" of another person includes:

1. The spouse of such other natural person;
2. The parents of such other natural person and their lineal descendants and the parents of such other natural person's spouse and their lineal descendants;
3. Any person who directly or indirectly owns or controls, or holds with power to vote, 10 percent or more of the outstanding voting securities of such other person;
4. Any person who directly or indirectly owns 10 percent or more of the outstanding voting securities which are directly or indirectly owned or controlled, or held with power to vote, by such other person;
5. Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;
6. Any director, officer, trustee, partner, owner, manager, joint venturer, or employee, or other person performing duties similar to those of persons in the aforementioned positions, of such other person;
7. If such other person is an investment company, any investment adviser of such company or any member of an advisory board of such company;
8. If such other person is an unincorporated investment company not having a board of directors, the depositor of such company; or
9. Any person who has entered into an agreement, written or unwritten, to act in concert with such other person in acquiring, or limiting the disposition of, securities of a specialty insurer or controlling company which is a stock corporation or in acquiring, or limiting the disposition of, an ownership interest of a specialty insurer or controlling company which is not a stock corporation.

(c) For the purposes of this section, the term "controlling company" means any corporation, trust, or association owning, directly or indirectly, 25 percent or more of the

voting securities of one or more specialty insurance companies which are stock corporations, or 25 percent or more of the ownership interest of one or more specialty insurance companies which are not stock corporations.
(d) For the purpose of this section, the term "natural person" means an individual.
(e) For the purpose of this section, the term "person" includes a natural person, corporation, association, trust, general partnership, limited partnership, joint venture, firm, proprietorship, or any other entity which may hold a license or certificate as a specialty insurer.
(14) The commission may adopt, amend, or repeal rules that are necessary to implement the provisions of this section, pursuant to chapter 120.

627.410 Filing, approval of forms.—

(6)(a) An insurer may not deliver, issue for delivery, or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the office applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.
(b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof, as specified in such rule, to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 are for informational purposes.
(c) Every filing made pursuant to this subsection shall be made within the same time period, and shall be deemed to be approved under the same conditions, as provided in subsection (2).
(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, is prohibited from applying the following rating practices:
1. Select and ultimate premium schedules.
2. Premium class definitions that classify insured based on year of issue or duration since issue.
3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.
(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form is not considered to be available for purchase unless the insurer has actively offered it for sale during the previous 12 months.
1. An insurer may discontinue the availability of a policy form if the insurer provides its decision to the office in writing at least 30 days before discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer may no longer offer the policy form or certificate form for sale in this state.
2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. may not file for approval a new policy form providing benefits similar to the discontinued form for 5 years after the insurer provides notice to the office of the discontinuance. The period of discontinuance may be reduced if the office determines that a shorter period is

appropriate. The requirements of this subparagraph do not apply to the discontinuance of a policy form because it does not comply with PPACA.
3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes, except that the experience of grandfathered health plans and nongrandfathered health plans shall be separated.
(7) Each insurer subject to subsection (6) shall make an annual filing with the office within 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. After receiving a request to be exempted from the provisions of this section, the office may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.
(a) The filing shall be satisfied by one of the following methods:
1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules adopted by the commission.
2. If no rate change is proposed, a filing that consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the commission.
(b) As used in this section, the term "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants who have a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.
(c) If at the time a filing is required an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office by the date the filing is due.
(d) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days after the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made until such time as the office determines that the required filing is properly submitted.

627.413 Contents of policies, in general; identification

(4) All policies and annuity contracts issued by insurers, and the forms thereof filed with the office, shall have printed thereon an appropriate designating letter or figure, or combination of letters or figures or terms identifying the respective forms of policies or contracts. Whenever any change is made in any such form, the designating letters, figures, or terms thereon shall be correspondingly changed.

627.4145 Readable language in insurance policies.—
(1) Every policy shall be readable as required by this section. For the purposes of this section, the term "policy" means a policy form or endorsement. A policy is deemed readable if:
(a) The text achieves a minimum score of 45 on the Flesch reading ease test as computed in subsection (5) or an equivalent score on any other test comparable in result and approved by the office;
(b) It uses layout and spacing which separate the paragraphs from each other and from the border of the paper;

(c) It has section titles that are captioned in boldfaced type or that otherwise stand out significantly from the text;
(d) It avoids the use of unnecessarily long, complicated, or obscure words, sentences, paragraphs, or constructions;
(e) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders; and
(f) It contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words or more than three pages.
(2) The office may authorize a lower score than the Flesch reading ease test score required in subsection (1) whenever it finds that a lower score will provide a more accurate reflection of the readability of a policy form, is warranted by the nature of a particular policy form or type or class of policy forms, or is the result of language which is used to conform to the requirements of any law.
(3) A filing subject to this section shall be accompanied by a certification signed by an officer of the insurer stating that the policy meets the requirements of subsection (1). Such certification shall state that the policy meets the minimum reading ease test score on the test used or that the score is lower than the minimum required but should be approved in accordance with subsection (2). The office may require the submission of further information to verify any certification.
(4) Any non-English language policy shall be deemed to be in compliance with this section if the insurer certifies that such policy is translated from an English language policy which complies with this section.
(5) A Flesch reading ease test score shall be measured by the following method:
(a) For policy forms containing 10,000 words or fewer of text, the entire form shall be analyzed. For policy forms containing more than 10,000 words, the readability of two 200-word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.
(b) The total number of words in the text shall be counted and divided by the total number of sentences, and the figure obtained shall be multiplied by a factor of 1.015.
(c) The total number of syllables shall be counted and divided by the total number of words, and the figure obtained shall be multiplied by a factor of 84.6.
(d) The sum of the figures computed under paragraphs (b) and (c) subtracted from 206.835 equals the Flesch reading ease test score for the policy form.
(e) For purposes of this subsection:
1. A contraction, hyphenated word, or numerals and letters, when separated by spaces, shall be counted as one word; and
2. A unit of words ending with a period, semicolon, or colon, excluding headings and captions, shall be counted as one sentence.
(f) The term "text" as used in this subsection includes all printed matter except:
1. The name and address of the insurer; the name, number, or title of the policy; the table of contents or index; captions and subcaptions; specification pages; schedules; or tables;
2. Policy language required by any collectively bargained agreement;
3. Any medical terminology;
4. Words which are defined in the policy; and
5. Any policy language required by law, if the insurer identifies the language or terminology excepted by this paragraph and certifies to the office, in writing, that the language or terminology is entitled to be excepted under this paragraph.
(g) At the option of the insurer, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they are to be used.
(6) This section does not apply to:
(a) Any policy which is a security subject to federal jurisdiction;

(b) Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit health insurance policy; however, this paragraph does not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this state;
(c) Any group annuity contract which serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;
(d) Any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates such forms must be approved under this section;
(e) Any policy or form, or partial revision thereof, or renewal thereof, which policy or form is filed prior to October 1, 1983; or
(f) Endorsements filed on or after October 1, 1983, which modify policy forms prior to October 1, 1983.
(g) Mortgage guaranty insurance policies, as defined in s. 635.011.
(7) This section applies to forms filed on or after October 1, 1983.

627.6699 Employee Health Care Access Act.—

(12) STANDARDS TO ASSURE FAIR MARKETING.—

(d) A small employer carrier shall not, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer except if the compensation arrangement provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

627.6735 Order to discontinue certain advertising.—An insurer must file with the office all advertisements for Medicare supplement policies pursuant to rules adopted by the commission. If, in the opinion of the office, any advertisement by a Medicare supplement policy insurer violates any of the provisions of part IX of chapter 626 or any rule of the commission, the office may enter an immediate order requiring that the use of the advertisement be discontinued. If requested by the insurer, the office shall conduct a hearing within 10 days of the entry of such order. If, after the hearing or by agreement with the insurer, a final determination is made that the advertising was in fact violative of any provision of part IX of chapter 626 or of any rule of the commission, the office may, in lieu of revocation of the certificate of authority, require the publication of a corrective advertisement; impose an administrative penalty of up to $10,000; and, in the case of an initial solicitation, require that the insurer, prior to accepting any application received in response to the advertisement, provide an acceptable clarification of the advertisement to each individual applicant.

627.682 Filing, approval of forms.—All forms of policies, certificates of insurance, statements of insurance, applications for insurance, binders, endorsements, and riders of credit life or disability insurance delivered or issued for delivery in this state shall be filed with and approved by the office before use as provided in ss. 627.410 and 627.411. In

addition to grounds as specified in s. 627.411, the office, upon compliance with the procedures set forth in s. 627.410, shall disapprove any such form and may withdraw any previous approval thereof if the benefits provided therein are not reasonable in relation to the premiums charged, or if it contains provisions which are unjust, unfair, inequitable, misleading, or deceptive or which encourage misrepresentation of such policy.

627.9407 Disclosure, advertising, and performance standards for long-term care insurance.—

(2) ADVERTISING.—The commission shall adopt rules establishing standards for the advertising, marketing, and sale of long-term care insurance policies in order to protect applicants from unfair or deceptive sales or enrollment practices. An insurer shall file with the office any long-term care insurance advertising material intended for use in this state and may immediately begin using such material upon filing, subject to subsequent disapproval by the office. Following receipt of a notice of disapproval or a withdrawal of approval, the insurer must immediately cease use of the disapproved material. The office may also disapprove an advertisement at any time and enter an immediate order requiring that the use of the advertisement be discontinued if it determines that the advertisement violates this part, part IX of chapter 626, or any rule of the commission.

628.4615 Specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.—
(1) For the purposes of this section, the term "specialty insurer" means any person holding a license or certificate of authority as:
(a) A motor vehicle service agreement company authorized to issue motor vehicle service agreements as those terms are defined in s. 634.011;
(b) A home warranty association authorized to issue "home warranties" as those terms are defined in s. 634.301;
(c) A service warranty association authorized to issue "service warranties" as those terms are defined in s. 634.401(13) and (14);
(d) A prepaid limited health service organization authorized to issue prepaid limited health service contracts, as those terms are defined in chapter 636;
(e) An authorized health maintenance organization operating pursuant to s. 641.21;
(f) An authorized prepaid health clinic operating pursuant to s. 641.405;
(g) A legal expense insurance corporation authorized to engage in a legal expense insurance business pursuant to s. 642.021;
(h) A provider that is licensed to operate a facility that undertakes to provide continuing care as those terms are defined in s. 651.011;
(i) A multiple-employer welfare arrangement operating pursuant to ss. 624.436-624.446;
(j) A premium finance company authorized to finance insurance premiums pursuant to s. 627.828; or
(k) A corporation authorized to accept donor annuity agreements pursuant to s. 627.481.
(2) A person may not, individually or in conjunction with any affiliated person of such person, directly or indirectly, conclude a tender offer or exchange offer for, enter into any agreement to exchange securities for, or otherwise finally acquire, 10 percent or more of the outstanding voting securities of a specialty insurer which is a stock corporation or of a controlling company of a specialty insurer which is a stock corporation; or conclude an acquisition of, or otherwise finally acquire, 10 percent or more of the ownership interest of a specialty insurer which is not a stock corporation or of a controlling company of a specialty insurer which is not a stock corporation, unless:

(a) The person or affiliated person has filed with the office and sent by registered mail to the principal office of the specialty insurer and controlling company a letter of notification regarding the transaction or proposed transaction no later than 5 days after any form of tender offer or exchange offer is proposed, or no later than 5 days after the acquisition of the securities or ownership interest if no tender offer or exchange offer is involved. The notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;
(b) The person or affiliated person has filed with the office an application signed under oath and prepared on forms prescribed by the commission which contains the information specified in subsection (4). The application must be completed and filed within 30 days after any form of tender offer or exchange offer is proposed, or after the acquisition of the securities if no tender offer or exchange offer is involved; and
(c) The office has approved the tender offer or exchange offer, or acquisition if no tender offer or exchange offer is involved.
(3) This section does not apply to any acquisition of voting securities or ownership interest of a specialty insurer or of a controlling company by any person who, on July 9, 1986, is the owner of a majority of such voting securities or ownership interest or who, on or after July 9, 1986, becomes the owner of a majority of such voting securities or ownership interest with the approval of the office under this section. The person or affiliated person filing the required notice in paragraph (2)(a) may request the office to waive the requirements of paragraph (2)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the specialty insurer. The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the specialty insurer.
(4) The application to be filed with the office and furnished to the specialty insurer and controlling company shall contain the following information and any additional information as the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the insureds of the insurer and of the public:
(a)1. The identity of, and the background information specified in subsection (5) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and,
2. If the acquisition is to be made by, or on behalf of, a person other than a natural person and as to any person who controls, either directly or indirectly, such other person, the identity of, and the background information specified in subsection (5) on:
a. Each director, officer, or trustee, if a corporation, or
b. Each partner, owner, manager, or joint venturer, or other person performing duties similar to those of persons in the aforementioned positions, if not a corporation,

for the person.

(b) The source and amount of the funds or other consideration used, or to be used, in making the acquisition.
(c) Any plans or proposals which such persons may have made to liquidate the specialty insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management; and any plans or proposals which such persons may have made to liquidate any controlling company of the specialty insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management.
(d) The nature and the extent of the controlling interest which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the

manner in which the controlling interest is to be acquired of a specialty insurer or controlling company which is not a stock corporation.
(e) The number of shares or other securities which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the securities are to be acquired.
(f) Information as to any contract, arrangement, or understanding with any party with respect to any of the securities of the specialty insurer or controlling company, including, but not limited to, information relating to the transfer of any of the securities, option arrangements, puts or calls, or the giving or withholding of proxies, which information names the party with whom the contract, arrangement, or understanding has been entered into and gives the details thereof.
(5)(a) The information as to the background and identity of each natural person, which information is required to be furnished pursuant to paragraph (4)(a), shall include:
1. The natural person's occupations, positions of employment, and offices held during the past 10 years.
2. The principal business and address of any business, corporation, or organization in which each such office of the natural person was held, or in which each such occupation or position of employment was carried on.
3. Whether the natural person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.
4. Whether the natural person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.
5. Whether, during the 10-year period, the natural person has been the subject of any proceeding under the federal Bankruptcy Act; or whether, during the 10-year period, any person or other business or organization in which the natural person was a director, officer, trustee, partner, owner, manager, or other official has been subject to any such proceeding, either during the time in which the natural person was a director, officer, or trustee, if a corporation, or a partner, owner, manager, joint venturer, or other official, if not a corporation, or within 12 months thereafter.
6. Whether, during the 10-year period, the natural person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law regulating the business of insurance, securities, or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities, or banking, together with details as to any such event.
7. Fingerprints of each person referred to in subsection (4).
(b) Any person filing the statement required by this section shall give all required information that is within the knowledge of:
1. The directors, officers, or trustees, if a corporation, or
2. The partners, owners, managers, or joint venturers, or others performing functions similar to those of a director, officer, or trustee, if not a corporation,

of the person making the filing and of any person controlling either directly or indirectly such person. If any material change occurs in the facts set forth in the application filed with the office pursuant to this section, an amendment setting forth such changes shall be filed immediately with the office, and a copy of the amendment shall be sent by registered mail to the principal office of the specialty insurer and to the principal office of the controlling company.

(6)(a) The acquisition application shall be reviewed in accordance with chapter 120. The office may on its own initiate, or, if requested to do so in writing by a substantially affected person, shall conduct, a proceeding to consider the appropriateness of the proposed filing. Time periods for purposes of chapter 120 shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10

days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time it finds an immediate danger to the public health, safety, and welfare of the insureds exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition disapproved and any further steps to conclude the acquisition ceased.

(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the specialty insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the specialty insurer unless advance written notice of the change in management is furnished to the office. A material change in the operation of the specialty insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the specialty insurer. A material change in the management of the specialty insurer is any change in management involving officers or directors of the specialty insurer or any person of the specialty insurer or controlling company having authority to dispose of or obligate 5 percent or more of the specialty insurer's capital or surplus. The office shall approve a material change in operations if it finds the applicable provisions of subsection (8) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (8) have not been met and in such case the specialty insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(7) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:

(a) Willfully violates this section;

(b) In violation of an order of the office issued pursuant to subsection (11), fails to divest himself or herself of any stock or ownership interest obtained in violation of this section or fails to divest himself or herself of any direct or indirect control of such stock or ownership interest, within 25 days after such order; or

(c) In violation of an order issued by the office pursuant to subsection (11), acquires an additional stock or ownership interest in a specialty insurer or controlling company or direct or indirect control of such stock or ownership interest, without complying with this section.

(8) The person or persons filing the application required by subsection (2) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed application if no proceeding is conducted, that:

(a) Upon completion of the acquisition, the specialty insurer will be able to satisfy the requirements for the issuance of a license or certificate to write the line of insurance for which it is presently licensed or certificated.

(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the specialty insurer or prejudice the interests of its insureds or the public.

(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:

1. To liquidate the specialty insurer, sell its assets, or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management, or

2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the specialty insurer,

is fair and free of prejudice to the insureds of the specialty insurer or to the public.

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the specialty insurer indicate that the acquisition is in the best interest of the insureds of the insurer and in the public interest.
(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the insureds of the specialty insurer and in the public interest to permit such persons to exercise control over the specialty insurer.
(f) The directors and officers, if such specialty insurer or controlling company is a stock corporation, or the trustees, partners, owners, managers, or joint venturers or other persons performing duties similar to those of persons in the aforementioned positions, if such specialty insurer or controlling company is not a stock corporation, to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation.
(g) The management of the specialty insurer after the acquisition will be competent and trustworthy, and will possess sufficient managerial experience so as to make the proposed operation of the specialty insurer not hazardous to the insurance-buying public.
(h) The management of the specialty insurer after the acquisition shall not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto.
(i) The acquisition is not likely to be hazardous or prejudicial to the insureds of the insurer or to the public.
(j) The effect of the acquisition would not substantially lessen competition in the line of insurance for which the specialty insurer is licensed or certified in this state or would not tend to create a monopoly therein.
(9) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition contrary to the provisions of this section is void. Upon the petition of the specialty insurer or the controlling company, the circuit court for the county in which the principal office of the specialty insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the provisions of this section. There shall be a private right of action in favor of the specialty insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the specialty insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by the specialty insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of an application pursuant to this section, or who files such an application, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.
(10) Any approval by the office under this section does not constitute a recommendation by the office of the tender offer or exchange offer, or acquisition, if no tender offer or exchange offer is involved. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or

s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.
(11) If the office determines that any person or any affiliated person of such person has acquired 10 percent or more of the outstanding voting securities of a specialty insurer or controlling company which is a stock corporation, or 10 percent or more of the ownership interest of a specialty insurer or controlling company which is not a stock corporation, without complying with the provisions of this section, the office may order that the person and any affiliated person of such person cease acquisition of the specialty insurer or controlling company and, if appropriate, divest itself of any stock or ownership interest acquired in violation of this section.
(12)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any specialty insurer or controlling company acquired in violation of this section.
(b) If any specialty insurer is subject to suspension or revocation pursuant to paragraph (a), the specialty insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its insureds, creditors, or stockholders or to the public.
(13)(a) For the purpose of this section, the term "acquisition" includes:
1. A tender offer or exchange offer for securities, assets, or other ownership interest;
2. An agreement to exchange securities for other securities, assets, or other ownership interest;
3. A merger of a person or affiliated person into a specialty insurer or a merger of any person with a specialty insurer;
4. A consolidation; or
5. Any other form of change of control

whereby any person or affiliated person acquires or attempts to acquire, directly or indirectly, 10 percent or more of the ownership interest or assets of a specialty insurer or of a controlling company. However, in the case of a health maintenance organization organized as a for-profit corporation, the provisions of s. 628.451 shall govern with respect to any merger or consolidation, and, in the case of a health maintenance organization organized as a not-for-profit corporation, the provisions of s. 628.471 shall govern with respect to any merger or consolidation.

(b) For the purpose of this section, the term "affiliated person" of another person includes:
1. The spouse of such other natural person;
2. The parents of such other natural person and their lineal descendants and the parents of such other natural person's spouse and their lineal descendants;
3. Any person who directly or indirectly owns or controls, or holds with power to vote, 10 percent or more of the outstanding voting securities of such other person;
4. Any person who directly or indirectly owns 10 percent or more of the outstanding voting securities which are directly or indirectly owned or controlled, or held with power to vote, by such other person;
5. Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;
6. Any director, officer, trustee, partner, owner, manager, joint venturer, or employee, or other person performing duties similar to those of persons in the aforementioned positions, of such other person;
7. If such other person is an investment company, any investment adviser of such company or any member of an advisory board of such company;
8. If such other person is an unincorporated investment company not having a board of directors, the depositor of such company; or

9. Any person who has entered into an agreement, written or unwritten, to act in concert with such other person in acquiring, or limiting the disposition of, securities of a specialty insurer or controlling company which is a stock corporation or in acquiring, or limiting the disposition of, an ownership interest of a specialty insurer or controlling company which is not a stock corporation.
(c) For the purposes of this section, the term "controlling company" means any corporation, trust, or association owning, directly or indirectly, 25 percent or more of the voting securities of one or more specialty insurance companies which are stock corporations, or 25 percent or more of the ownership interest of one or more specialty insurance companies which are not stock corporations.
(d) For the purpose of this section, the term "natural person" means an individual.
(e) For the purpose of this section, the term "person" includes a natural person, corporation, association, trust, general partnership, limited partnership, joint venture, firm, proprietorship, or any other entity which may hold a license or certificate as a specialty insurer.
(14) The commission may adopt, amend, or repeal rules that are necessary to implement the provisions of this section, pursuant to chapter 120.

641.19 Definitions.—

(5) "Copayment" means a specific dollar amount, except as otherwise provided for by statute, that the subscriber must pay upon receipt of covered health care services. Copayments may not be established in an amount that will prevent a person from receiving a covered service or benefit as specified in the subscriber contract approved by the office.

641.21 Application for certificate.—
(1) Before any entity may operate a health maintenance organization, it shall obtain a certificate of authority from the office. The office shall accept and shall begin its review of an application for a certificate of authority anytime after an organization has filed an application for a health care provider certificate pursuant to part III of this chapter. However, the office may not issue a certificate of authority to any applicant which does not possess a valid health care provider certificate issued by the agency. Each application for a certificate shall be on such form as the commission shall prescribe, shall be verified by the oath of two officers of the corporation and properly notarized, and shall be accompanied by the following:
(a) A copy of the articles of incorporation and all amendments thereto;
(b) A copy of the bylaws, rules and regulations, or similar form of document, if any, regulating the conduct of the affairs of the applicant;
(c) A list of the names, addresses, and official capacities with the organization of the persons who are to be responsible for the conduct of the affairs of the health maintenance organization, including all officers, directors, and owners of in excess of 5 percent of the common stock of the corporation. Such persons shall fully disclose to the office and the directors of the health maintenance organization the extent and nature of any contracts or arrangements between them and the health maintenance organization, including any possible conflicts of interest;
(d) A complete biographical statement on forms prescribed by the commission, and an independent investigation report and fingerprints obtained pursuant to chapter 624, of all of the individuals referred to in paragraph (c);
(e) A statement generally describing the health maintenance organization, its operations, and its grievance procedures;
(f) Forms of all health maintenance contracts, certificates, and member handbooks the applicant proposes to offer the subscribers, showing the benefits to which they are entitled,

together with a table of the rates charged, or proposed to be charged, for each form of such contract. A certified actuary shall:
1. Certify that the rates are neither inadequate nor excessive nor unfairly discriminatory;
2. Certify that the rates are appropriate for the classes of risks for which they have been computed; and
3. File an adequate description of the rating methodology showing that such methodology follows consistent and equitable actuarial principles;
(g) A statement describing with reasonable certainty the geographic area or areas to be served by the health maintenance organization;
(h) As to any applicant whose business plan indicates that it will receive Medicaid funds, a list of all contracts and agreements and any information relative to any payment or agreement to pay, directly or indirectly, a consultant fee, a broker fee, a commission, or other fee or charge related in any way to the application for a certificate of authority or the issuance of a certificate of authority, including, but not limited to, the name of the person or entity paying the fee; the name of the person or entity receiving the fee; the date of payment; and a brief description of the work performed. The contract, agreement, and related information shall, if requested, be provided to the office.
(i) An audited financial statement prepared on the basis of statutory accounting principles and certified by an independent certified public accountant, except that surplus notes acceptable to the office and meeting the requirements of this act shall be included in the calculation of surplus; and
(j) Such additional reasonable data, financial statements, and other pertinent information as the commission or office requires with respect to the determination that the applicant can provide the services to be offered.

641.22 Issuance of certificate of authority

(2) The health maintenance organization is actuarially sound.

(4) The procedures for offering comprehensive health care services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, sex, race, health, or economic status. However, this section does not prohibit reasonable underwriting classifications for the purposes of establishing contract rates, nor does it prohibit experience rating.

(6) The ownership, control, and management of the entity is competent and trustworthy and possesses managerial experience that would make the proposed health maintenance organization operation beneficial to the subscribers. The office shall not grant or continue authority to transact the business of a health maintenance organization in this state at any time during which the office has good reason to believe that:
(a) The ownership, control, or management of the organization includes any person:
1. Who is incompetent or untrustworthy;
2. Who is so lacking in health maintenance organization expertise as to make the operation of the health maintenance organization hazardous to potential and existing subscribers;
3. Who is so lacking in health maintenance organization experience, ability, and standing as to jeopardize the reasonable promise of successful operation;
4. Who is affiliated, directly or indirectly, through ownership, control, reinsurance transactions, or other business relations, with any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors; or

5. Whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors;
(b) Any person, including any stock subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the health maintenance organization, does not possess the financial standing and business experience for the successful operation of the health maintenance organization;
(c) Any person, including any stock subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the health maintenance organization, has been found guilty of, or has pled guilty or no contest to, any felony or crime punishable by imprisonment of 1 year or more under the laws of the United States or any state thereof or under the laws of any other country, which involves moral turpitude, without regard to whether a judgment or conviction has been entered by the court having jurisdiction in such case. However, in the case of a health maintenance organization operating under a subsisting certificate of authority, the health maintenance organization shall remove any such person immediately upon discovery of the conditions set forth in this paragraph when applicable to such person or under the order of the office, and the failure to so act by the organization is grounds for revocation or suspension of the health maintenance organization's certificate of authority; or
(d) Any person, including any stock subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the health maintenance organization, is now or was in the past affiliated, directly or indirectly, through ownership interest of 10 percent or more, control, or reinsurance transactions, with any business, corporation, or other entity that has been found guilty of or has pleaded guilty or nolo contendere to any felony or crime punishable by imprisonment for 1 year or more under the laws of the United States, any state, or any other country, regardless of adjudication. In the case of a health maintenance organization operating under a subsisting certificate of authority, the health maintenance organization shall immediately remove such person or immediately notify the office of such person upon discovery of the conditions set forth in this paragraph, either when applicable to such person or upon order of the office. The failure to remove such person, provide such notice, or comply with such order constitutes grounds for suspension or revocation of the health maintenance organization's certificate of authority.

(9) The health maintenance organization has a grievance procedure that will facilitate the resolution of subscriber grievances and that includes both formal and informal steps available within the organization.

641.221 Continued eligibility for certificate of authority.—In order to maintain its eligibility for a certificate of authority, a health maintenance organization shall continue to meet all conditions required to be met under this part and the rules promulgated thereunder for the initial application for and issuance of its certificate of authority under s. 641.22.

641.225 Surplus requirements.—
(1) Each health maintenance organization shall at all times maintain a minimum surplus in an amount that is the greater of $1,500,000, or 10 percent of total liabilities, or 2 percent of total annualized premium.

(2) The office shall not issue a certificate of authority unless the health maintenance organization has a minimum surplus in an amount which is the greater of:
(a) Ten percent of their total liabilities based on their startup projection as set forth in this part;
(b) Two percent of their total projected premiums based on their startup projection as set forth in this part; or
(c) $1,500,000, plus all startup losses, excluding profits, projected to be incurred on their startup projection until the projection reflects statutory net profits for 12 consecutive months.
(3) The commission may adopt rules to set uniform standards and criteria for the early warning that the continued operation of any health maintenance organization might be hazardous to its subscribers, creditors, or the general public, and to set standards for evaluating the financial condition of any health maintenance organization.
(4) A surplus note shall not be used to initially capitalize a health maintenance organization.
(5) In lieu of having any minimum surplus, the health maintenance organization may provide a written guarantee to assure payment of covered subscriber claims and all other liabilities of the health maintenance organization, provided that the written guarantee is made by a guaranteeing organization which:
(a) Has been in operation for 5 years or more and has a surplus, not including land, buildings, and equipment, of the greater of $2 million or 2 times the minimum surplus requirements of the health maintenance organization. In any determination of the financial condition of the guaranteeing organization, the definitions of assets, liabilities, and surplus set forth in this part shall apply, except that investments in or loans to any organizations guaranteed by the guaranteeing organization shall be excluded from surplus. If the guaranteeing organization is sponsoring more than one organization, the surplus requirement shall be increased by a multiple equal to the number of such organizations.
(b) Submits a guarantee that is approved by the office as meeting the requirements of this part, provided that the written guarantee contains a provision which requires that the guarantee be irrevocable unless the guaranteeing organization can demonstrate to the office that the cancellation of the guarantee will not result in the insolvency of the health maintenance organization and the office approves cancellation of the guarantee.
(c) Initially submits its audited financial statements, certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles, covering its two most current annual accounting periods.
(d) Submits annually, within 3 months after the end of its fiscal year, an audited financial statement certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles. The office may, as it deems necessary, require quarterly financial statements from the guaranteeing organization.
(6) A health maintenance organization that is authorized in this state and one or more other states, jurisdictions, or countries is subject to ss. 624.4085 and 624.40851.

641.285 Insolvency protection.—
(1) Each health maintenance organization shall deposit with the department cash or securities of the type eligible under s. 625.52, which shall have at all times a market value in the amount set forth in this subsection. The amount of the deposit shall be reviewed annually, or more often, as the office deems necessary. The market value of the deposit shall be a minimum of $300,000.
(2) If securities or assets deposited by a health maintenance organization under this part are subject to material fluctuations in market value, the office may, in its discretion, require the organization to deposit and maintain on deposit additional securities or assets in an amount as may be reasonably necessary to assure that the deposit will at all times have a market value of not less than the amount specified under this section. If for any reason the

market value of assets and securities of a health maintenance organization held on deposit in this state under this code falls below the amount required, the organization shall promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency. If the health maintenance organization has failed to cure the deficiency within 30 days after receipt of notice thereof by registered or certified mail from the office, the office may revoke the certificate of authority of the health maintenance organization.
(3) Whenever the office determines that the financial condition of a health maintenance organization has deteriorated to the point that the policyholders' or subscribers' best interests are not being preserved by the activities of a health maintenance organization, the office may require such health maintenance organization to deposit and maintain deposited in trust with the department for the protection of the health maintenance organization's policyholders, subscribers, and creditors, for such time as the office deems necessary, securities eligible for such deposit under s. 625.52 having a market value of not less than the amount that the office determines is necessary, which amount must not be less than $100,000 or greater than $2 million. The deposit required under this subsection is in addition to any other deposits required of a health maintenance organization pursuant to subsections (1) and (2).
(4) All income from deposits shall belong to the depositing health maintenance organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit, or any part thereof, after making a substitute deposit of cash or eligible securities or any combination of these or other acceptable measures of equal amount and value.

641.26 Annual and quarterly reports.—
(1) Every health maintenance organization shall, annually within 3 months after the end of its fiscal year, or within an extension of time therefor as the office, for good cause, may grant, in a form prescribed by the commission, file a report with the office, verified by the oath of two officers of the organization or, if not a corporation, of two persons who are principal managing directors of the affairs of the organization, properly notarized, showing its condition on the last day of the immediately preceding reporting period. Such report shall include:
(a) A financial statement of the health maintenance organization filed by electronic means in a computer-readable form using a format acceptable to the office.
(b) A financial statement of the health maintenance organization filed on forms acceptable to the office.
(c) An audited financial statement of the health maintenance organization, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant, prepared in accordance with statutory accounting principles.
(d) The number of health maintenance contracts issued and outstanding and the number of health maintenance contracts terminated.
(e) The number and amount of damage claims for medical injury initiated against the health maintenance organization and any of the providers engaged by it during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim.
(f) An actuarial certification that:
1. The health maintenance organization is actuarially sound, which certification shall consider the rates, benefits, and expenses of, and any other funds available for the payment of obligations of, the organization.
2. The rates being charged or to be charged are actuarially adequate to the end of the period for which rates have been guaranteed.

3. Incurred but not reported claims and claims reported but not fully paid have been adequately provided for.
4. The health maintenance organization has adequately provided for all obligations required by s. 641.35(3)(a).
(g) A report prepared by the certified public accountant and filed with the office describing material weaknesses in the health maintenance organization's internal control structure as noted by the certified public accountant during the audit. The report must be filed with the annual audited financial report as required in paragraph (c). The health maintenance organization shall provide a description of remedial actions taken or proposed to correct material weaknesses, if the actions are not described in the independent certified public accountant's report.
(h) Such other information relating to the performance of health maintenance organizations as is required by the commission or office.
(2) The office may require updates of the actuarial certification as to a particular health maintenance organization if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the health maintenance organization. Workpapers in support of the statement of the updated actuarial certification must be provided to the office upon request.

641.27 Examination by the department.—
(1) The office shall examine the affairs, transactions, accounts, business records, and assets of any health maintenance organization as often as it deems it expedient for the protection of the people of this state, but not less frequently than once every 5 years. However, except when the medical records are requested and copies furnished pursuant to s. 456.057, medical records of individuals and records of physicians providing service under contract to the health maintenance organization shall not be subject to audit, although they may be subject to subpoena by court order upon a showing of good cause. For the purpose of examinations, the office may administer oaths to and examine the officers and agents of a health maintenance organization concerning its business and affairs. The examination of each health maintenance organization by the office shall be subject to the same terms and conditions as apply to insurers under chapter 624. In no event shall expenses of all examinations exceed a maximum of $50,000 for any 1-year period. Any rehabilitation, liquidation, conservation, or dissolution of a health maintenance organization shall be conducted under the supervision of the department, which shall have all power with respect thereto granted to it under the laws governing the rehabilitation, liquidation, reorganization, conservation, or dissolution of life insurance companies.
(2) The office may contract, at reasonable fees for work performed, with qualified, impartial outside sources to perform audits or examinations or portions thereof pertaining to the qualification of an entity for issuance of a certificate of authority or to determine continued compliance with the requirements of this part, in which case the payment must be made directly to the contracted examiner by the health maintenance organization examined, in accordance with the rates and terms agreed to by the office and the examiner. Any contracted assistance shall be under the direct supervision of the office. The results of any contracted assistance shall be subject to the review of, and approval, disapproval, or modification by, the office.

641.29 Fees.—Every health maintenance organization shall pay to the office the following fees:
(1) For filing a copy of its application for a certificate of authority or amendment thereto, a nonrefundable fee in the amount of $1,000.

(2) For filing each annual report, which must be filed by electronic means in a computer-readable form, $150.

641.3007 HIV infection and AIDS for contract purposes.—

(4) UTILIZATION OF MEDICAL TESTS.—

(b) Prior to testing, the health maintenance organization must disclose its intent to test the person for the HIV infection or for a specific sickness or medical condition derived therefrom and must obtain the person's written informed consent to administer the test. Written informed consent shall include a fair explanation of the test, including its purpose, potential uses, and limitations, and the meaning of its results and the right to confidential treatment of information. Use of a form approved by the office shall raise a conclusive presumption of informed consent.
(c) An applicant shall be notified of a positive test result by a physician designated by the applicant or, in the absence of such designation, by the Department of Health. Such notification must include:
1. Face-to-face posttest counseling on the meaning of the test results; the possible need for additional testing; and the need to eliminate behavior which might spread the disease to others;
2. The availability in the geographic area of any appropriate health care services, including mental health care, and appropriate social and support services;
3. The benefits of locating and counseling any individual by whom the infected individual may have been exposed to human immunodeficiency virus and any individual whom the infected individual may have exposed to the virus; and
4. The availability, if any, of the services of public health authorities with respect to locating and counseling any individual described in subparagraph 3.

641.31 Health maintenance contracts.—

(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. The commission, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.
(3)(a) If a health maintenance organization desires to amend any contract with its subscribers or any certificate or member handbook, or desires to change any basic health maintenance contract, certificate, grievance procedure, or member handbook form, or application form where written application is required and is to be made a part of the contract, or printed amendment, addendum, rider, or endorsement form or form of renewal certificate, it may do so, upon filing with the office the proposed change or amendment. Any proposed change shall be effective immediately, subject to disapproval by the office. Following receipt of notice of such disapproval or withdrawal of approval, no health maintenance organization shall issue or use any form disapproved by the office or as to which the office has withdrawn approval.
(b) Any change in the rate is subject to paragraph (d) and requires at least 30 days' advance written notice to the subscriber. In the case of a group member, there may be a contractual agreement with the health maintenance organization to have the employer provide the required notice to the individual members of the group.

(c) The office shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, if the form:
1. Is in any respect in violation of, or does not comply with, any provision of this part or rule adopted thereunder.
2. Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.
3. Has any title, heading, or other indication of its provisions which is misleading.
4. Is printed or otherwise reproduced in such a manner as to render any material provision of the form substantially illegible.
5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.
6. Excludes coverage for human immunodeficiency virus infection or acquired immune deficiency syndrome or contains limitations in the benefits payable, or in the terms or conditions of such contract, for human immunodeficiency virus infection or acquired immune deficiency syndrome which are different than those which apply to any other sickness or medical condition.
(d) Any change in rates charged for the contract must be filed with the office not less than 30 days in advance of the effective date. At the expiration of such 30 days, the rate filing shall be deemed approved unless prior to such time the filing has been affirmatively approved or disapproved by order of the office. The approval of the filing by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such filing, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such filing shall be deemed approved. This paragraph does not apply to group health contracts effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claims costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.
(e) It is not the intent of this subsection to restrict unduly the right to modify rates in the exercise of reasonable business judgment.

(5) Every subscriber shall receive a clear and understandable description of the method of the health maintenance organization for resolving subscriber grievances, and the method shall be set forth in the contract, certificate, and member handbook. The organization shall also furnish, at the time of initial enrollment and when necessary due to substantial changes to the grievance process a separate and additional communication prepared or approved by the office notifying the contract holder of a group contract or subscriber of an individual contract of their rights and responsibilities under the grievance process.

641.31074 Guaranteed renewability of coverage.—
(1) Except as otherwise provided in this section, a health maintenance organization that issues a health insurance contract must renew or continue in force such coverage at the option of the contract holder.
(2) A health maintenance organization may nonrenew or discontinue a contract based only on one or more of the following conditions:
(a) The contract holder has failed to pay premiums or contributions in accordance with the terms of the contract or the health maintenance organization has not received timely premium payments.

(b) The contract holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the contract.
(c) The contract holder has failed to comply with a material provision of the plan which relates to rules for employer contributions or group participation.
(d) The health maintenance organization is ceasing to offer coverage in such a market in accordance with subsection (3).
(e) There is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the health maintenance organization or in the area in which the health maintenance organization is authorized to do business.
(f) In the case of coverage that is made available only through one or more bona fide associations as defined in s. 627.6571(5), the membership of an employer in the association, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor that relates to any covered individuals.
(3)(a) A health maintenance organization may discontinue offering a particular contract form only if:
1. The health maintenance organization provides notice to each contract holder provided coverage of this form in such market, and participants and beneficiaries covered under such coverage, of such discontinuation at least 90 days prior to the date of the nonrenewal of such coverage;
2. The health maintenance organization offers to each contract holder provided coverage of this form in such market the option to purchase all, or in the case of the large group market, any other health insurance coverage currently being offered by the health maintenance organization in such market; and
3. In exercising the option to discontinue coverage of this form and in offering the option of coverage under subparagraph 2., the health maintenance organization acts uniformly without regard to the claims experience of those contract holders or any health-status-related factor that relates to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.
(b)1. In any case in which a health maintenance organization elects to discontinue offering all coverage in the individual market, the small group market, the large group market, or any combination thereof in this state, coverage may be discontinued by the insurer only if:
a. The health maintenance organization provides notice to the office and to each contract holder, and participants and beneficiaries covered under such coverage, of such discontinuation at least 180 days prior to the date of the nonrenewal of such coverage; and
b. All health insurance issued or delivered for issuance in this state in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.
2. In the case of a discontinuation under subparagraph 1. in a market, the health maintenance organization may not provide for the issuance of any health maintenance organization contract coverage in the market in this state during the 5-year period beginning on the date of the discontinuation of the last insurance contract not renewed.
(4) At the time of coverage renewal, a health maintenance organization may modify the coverage for a product offered:
(a) In the large group market;
(b) In the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, as defined in s. 627.6571(5), such modification is consistent with s. 627.6699 and effective on a uniform basis among group health plans with that product; or
(c) In the individual market if the modification is consistent with the laws of this state and effective on a uniform basis among all individuals with that policy form.
(5) In applying this section in the case of health insurance coverage that is made available by a health maintenance organization in the small group market or large group market to

employers only through one or more associations, a reference to "contract holder" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

641.3922 Conversion contracts; conditions

(3) CONVERSION PREMIUM.—The premium for the converted contract shall be determined in accordance with premium rates applicable to the age and class of risk of each person to be covered under the converted contract and to the type and amount of coverage provided. However, the premium for the converted contract may not exceed 200 percent of the standard risk rate, as established by the office under s. 627.6675(3). The mode of payment for the converted contract shall be quarterly or more frequently at the option of the organization, unless otherwise mutually agreed upon between the subscriber and the organization.

690-167

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

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

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other

section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit

committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 690-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—
(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(o) Illegal dealings in premiums; excess or reduced charges for insurance.—

3.a. Imposing or requesting an additional premium for a policy of motor vehicle liability, personal injury protection, medical payment, or collision insurance or any combination thereof or refusing to renew the policy solely because the insured was involved in a motor vehicle accident unless the insurer's file contains information from which the insurer in good faith determines that the insured was substantially at fault in the accident.

627.420 Binders.—Binders or other contracts for temporary property, marine, casualty, or surety insurance may be made orally or in writing, and shall be deemed to include all the usual terms of the policy as to which the binder was given together with such applicable endorsements as are designated in the binder, except as superseded by the clear and express terms of the binder. No notice of cancellation or notice of nonrenewal otherwise required by this chapter shall be required unless the duration of the binder exceeds 60 days. However, for purposes of ss. 627.728 and 627.7281, an insurer shall give 5 days' prior notice of cancellation of a binder, unless the binder is replaced by a policy or another binder in the same or another company.

627.421 Delivery of policy.—
(1) Subject to the insurer's requirement as to payment of premium, every policy shall be mailed, delivered, or electronically transmitted to the insured or to the person entitled thereto not later than 60 days after the effectuation of coverage. Notwithstanding any other provision of law, an insurer may allow a policyholder of personal lines insurance to affirmatively elect delivery of the policy documents, including, but not limited to, policies, endorsements, notices, or documents, by electronic means in lieu of delivery by mail. Electronic transmission of a policy for commercial risks, including, but not limited to, workers' compensation and employers' liability, commercial automobile liability, commercial automobile physical damage, commercial lines residential property, commercial

nonresidential property, farmowners insurance, and the types of commercial lines risks set forth in s. 627.062(3)(d), constitutes delivery to the insured or to the person entitled to delivery, unless the insured or the person entitled to delivery communicates to the insurer in writing or electronically that he or she does not agree to delivery by electronic means. Electronic transmission shall include a notice to the insured or to the person entitled to delivery of a policy of his or her right to receive the policy via United States mail rather than via electronic transmission. A paper copy of the policy shall be provided to the insured or to the person entitled to delivery at his or her request.

(2) In the event the original policy is delivered or is so required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any motor vehicle, and in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to such vehicle is insured, a duplicate of such policy setting forth the name and address of the insurer, insurance classification of vehicle, type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy, or memorandum thereof containing the same such information, shall be delivered by the vendor, mortgagee, or pledgee to each such vendee, mortgagor, or pledgor named in the policy or coming within the group of persons designated in the policy to be so included. If the policy does not provide coverage of legal liability for injury to persons or damage to the property of third parties, a statement of such fact shall be printed, written, or stamped conspicuously on the face of such duplicate policy or memorandum. This subsection does not apply to inland marine floater policies.

(3) Any automobile liability or physical damage policy shall contain on the front page a summary of major coverages, conditions, exclusions, and limitations contained in that policy. Any such summary shall state that the issued policy should be referred to for the actual contractual governing provisions. The company may, in lieu of the summary, provide a readable policy.

(4) Notwithstanding subsections (1) and (2), property and casualty insurance policies and endorsements that do not contain personally identifiable information may be posted on the insurer's Internet website. If the insurer elects to post insurance policies and endorsements on its Internet website in lieu of mailing or delivery to insureds, the insurer must comply with the following:

(a) Each policy and endorsement must be easily accessible on the insurer's Internet website for as long as the policy and endorsement remain in force.

(b) The insurer must archive all of its expired policies and endorsements on its Internet website and make any expired policy and endorsement available upon an insured's request for at least 5 years after expiration of the policy and endorsement.

(c) Each policy and endorsement must be posted in a manner that enables the insured to print and save the policy and endorsement using a program or application that is widely available on the Internet without charge.

(d) When the insurer issues an initial policy or any renewal, the insurer must notify the insured, in the manner the insurer customarily uses to communicate with the insured, that the insured has the right to request and obtain without charge a paper or electronic copy of the insured's policy and endorsements.

(e) On each declarations page issued to the insured, the insurer must clearly identify the exact policy form and endorsement form purchased by the insured.

(f) If the insurer changes any policy form or endorsement, the insurer must notify the insured, in the manner the insurer customarily uses to communicate with the insured, that the insured has the right to request and obtain without charge a paper or electronic copy of such form or endorsement.

627.728 Cancellations; nonrenewals.—

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

(a) "Policy" means the bodily injury and property damage liability, personal injury protection, medical payments, comprehensive, collision, and uninsured motorist coverage portions of a policy of motor vehicle insurance delivered or issued for delivery in this state:
1. Insuring a natural person as named insured or one or more related individuals resident of the same household; and
2. Insuring only a motor vehicle of the private passenger type or station wagon type which is not used as a public or livery conveyance for passengers or rented to others; or insuring any other four-wheel motor vehicle having a load capacity of 1,500 pounds or less which is not used in the occupation, profession, or business of the insured other than farming; other than any policy issued under an automobile insurance assigned risk plan or covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards.

The term "policy" does not include a binder as defined in s. 627.420 unless the duration of the binder period exceeds 60 days.

(b) "Renewal" or "to renew" means the issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term. Any policy with a policy period or term of less than 6 months or any policy with no fixed expiration date shall for the purpose of this section be considered as if written for successive policy periods or terms of 6 months.
(c) "Nonpayment of premium" means failure of the named insured to discharge when due any of her or his obligations in connection with the payment of premiums on a policy or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit, or failure to maintain membership in an organization if such membership is a condition precedent to insurance coverage. "Nonpayment of premium" also means the failure of a financial institution to honor an insurance applicant's check after delivery to a licensed agent for payment of a premium, even if the agent has previously delivered or transferred the premium to the insurer; further, if the dishonored check represents the initial premium payment, the contract shall be void ab initio unless the nonpayment is cured within the earlier of 5 days after actual notice by certified mail is received by the applicant or 15 days after notice is sent to the applicant by certified mail or registered mail, and if the contract is void, any premium received by the insurer from a third party shall be refunded to that party in full. If a dishonored check is made payable to the insurer, the insurer may cancel the policy in accordance with paragraph (3)(a).
(2) No notice of cancellation of a policy shall be effective unless it is based on one or more of the following grounds:
(a) Nonpayment of premium.
(b) Material misrepresentation or fraud.
(c) The driver license or motor vehicle registration of the named insured or of any other operator who either resides in the same household or customarily operates an automobile insured under the policy has been under suspension or revocation during the policy period or the 180 days immediately preceding its effective date or, if the policy is a renewal, during its policy period. This subsection shall not apply to any policy which has been in effect less than 60 days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy. Nothing in this subsection shall apply to nonrenewal.
(3)(a) No notice of cancellation of a policy to which this section applies shall be effective unless mailed or delivered by the insurer to the first-named insured and to the first-named insured's insurance agent at least 45 days prior to the effective date of cancellation, except that, when cancellation is for nonpayment of premium, at least 10 days' notice of cancellation accompanied by the reason therefor shall be given. No notice of cancellation of

a policy to which this section applies shall be effective unless the reason or reasons for cancellation accompany the notice of cancellation.
(b) Nothing in this subsection shall apply to nonrenewal.
(c) Nothing in this subsection shall apply in cases in which the premium has been financed and the premium finance company has complied with the notice provisions of s. 627.848.
(4)(a) No insurer shall fail to renew a policy unless it mails or delivers to the first-named insured, at the address shown in the policy, and to the first-named insured's insurance agent at her or his business address, at least 45 days' advance notice of its intention not to renew; and the reasons for refusal to renew must accompany such notice. This subsection does not apply:
1. If the insurer has manifested its willingness to renew; or
2. In case of nonpayment of premium.

Notwithstanding the failure of an insurer to comply with this subsection, the policy shall terminate on the effective date of any other automobile liability insurance policy procured by the insured with respect to any automobile designated in both policies. Unless a written explanation for refusal to renew accompanies the notice of intention not to renew, the policy shall remain in full force and effect.

(b) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.
(c) No insurer shall fail to renew a policy for reasons based entirely on the sex, occupation, marital status, residence, military service, or age of the insured, or on the principal place of garaging the insured vehicle in this state, or based on any combination of such factors. No insurer shall fail to renew a policy for reasons based on the race, color, creed, or national origin of the insured or for any reason which is arbitrary or capricious.
(d) Instead of canceling or nonrenewing a policy, an insurer may, upon expiration of the policy term, transfer a policy to another insurer under the same ownership or management as the transferring insurer, by giving the first-named insured at least 45 days' advance notice of its intent to transfer the policy and of the premium and the specific reasons for any increase in the premium.
(5) United States postal proof of mailing or certified or registered mailing of notice of cancellation, of intention not to renew, or of reasons for cancellation, or of the intention of the insurer to issue a policy by an insurer under the same ownership or management, to the first-named insured at the address shown in the policy shall be sufficient proof of notice.
(6) When a policy is canceled, other than for nonpayment of premium, or in the event of failure to renew a policy to which subsection (4) applies, the insurer shall notify the first-named insured of her or his possible eligibility for insurance through the Automobile Joint Underwriting Association. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew and shall state that such notice of availability of the Automobile Joint Underwriting Association is given pursuant to this section.
(7) Except in the case of cancellation for nonpayment of premium or nonrenewal of the policy, the notice of cancellation as provided by this section must contain the following words which are to be prominently displayed: "You are permitted by law to appeal this cancellation. An appeal must be filed no later than 20 days before the effective date of cancellation set forth in this notice. Forms for such appeal and the regulations pertaining thereto may be obtained from the office. The office does not have the authority to extend the effective date of cancellation; therefore you should obtain replacement coverage prior to the effective date of cancellation."
(8)(a) Within 2 working days after receipt of a timely appeal of the notice of cancellation, the office shall initiate a proceeding. If informal procedures fail to resolve the appeal, the office shall, upon request of the insured, call a hearing upon 10 days' notice to the parties to

be held by a disinterested employee of the office. Proceedings pursuant to this subsection are not subject to the provisions of chapter 120.
(b) Each insurer subject to this section shall maintain on file with the office the name and address of the person authorized to receive notices pursuant to this section on behalf of the insurer.
(c) The office shall, at the conclusion of the proceeding or hearing or not later than 2 working days thereafter, issue its written findings to the parties; and, if it finds for the named insured, it shall either order the insurer to rescind its notice of cancellation or, if the date cancellation is to be effective has elapsed, order the policy reinstated from the date of cancellation, and such coverage shall be continuous to, and shall operate prospectively from, the date of cancellation. However, no policy shall be reinstated while the named insured is in arrears in payment of premium on such policy. If the office finds for the insurer, its written findings shall so state.
(d) Reinstatement of a policy under this subsection shall not operate in any way to extend the expiration, termination, or anniversary date provided in the policy. Upon such reinstatement, costs and attorney's fees may be assessed by the office and paid to the named insured by an insurer who has wrongfully canceled a policy, as determined by the proceeding or hearing provided for in paragraph (c).
(9) The office shall deposit all fees provided for in this section into the Insurance Regulatory Trust Fund.
(10) No cause of action in the nature of defamation, invasion of privacy, or negligence shall arise against any person for disclosing personal or privileged information in accordance with this section, nor shall such a cause of action arise against any person for furnishing personal or privileged information to an insurance institution, agent, or insurance-support organization; however, this section shall provide no immunity for disclosing or furnishing false information through gross negligence or with malice or willful intent to injure any person.
(11) There shall be no liability on the part of, and no cause of any action of any nature shall arise against, any insurer or its authorized representatives, agents, or employees of any firm, person, or corporation furnishing to the insurer or insured information as to reasons for cancellation or refusal to renew, for any statement made by any of them in any written notice of cancellation or refusal to renew, for the providing of information pertaining thereto, or for statements made or evidence submitted at any hearing conducted in connection therewith; provided that this subsection shall provide no immunity for disclosing or furnishing false information through gross negligence or with malice or willful intent to injure any person.
(12) No later than 10 business days after termination of a policy subject to this section, the insurer must send written or electronic notice of the termination to all holders of liens on the subject vehicle which lienholders are known to the insurer. Electronic notice is valid only by prior agreement between the insurer and the lienholder.

627.7282 Notice of additional premium; cancellation upon nonpayment.—
(1) Upon a determination by an insurer that, in accordance with its rate filings and the applicable laws of this state relating to private passenger motor vehicle insurance, a policyholder has been charged a premium that is incorrect for the coverage set forth in the insurance application, the insurer shall immediately provide notice to the policyholder of the amount of additional premium due to the insurer and that the policyholder has the following options:
(a) The policyholder has a period of 10 days, or a longer period if specified by the insurer, from receipt of the notice within which to pay the additional amount of premium due and thereby maintain the policy in full force under its original terms.

(b) The policyholder has a period of 10 days, or a longer period if specified by the insurer, from receipt of the notice within which to cancel the policy and demand a refund of any unearned premiums.
(c) If the policyholder fails to timely respond to the notice, the insurer shall cancel the policy and return any unearned premium to the insured. The date on which the policy will be canceled shall be stated in the notice and shall in no case be less than 14 days after the date of the notice.
(2) The amount of unearned premium due to the policyholder as a result of cancellation in accordance with subsection (1) shall be calculated on a pro rata basis.
(3) No insurer shall unilaterally alter or modify the policy period for a private passenger automobile insurance policy to provide an expiration date that is prior to the date specified in the policyholder's application, except as provided in this section.
(4) This section shall not be construed to limit insurers' rights to cancel in accordance with applicable provisions of the insurance code.
(5) The commission may adopt rules prescribing the format of the notice.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs

elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period

of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.

(f) Number of new policies written.

(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:

1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.321 Witnesses and evidence.—
(1) As to any examination, investigation, or hearing being conducted under this code, a person designated by the department or office, respectively:
(a) May administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence;

636.067 Rules.—The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this act. A violation of any such rule subjects the violator to the provisions of s. 636.048.

636.232 Rules.—The commission may adopt rules to administer this part, including rules for the licensing of discount medical plan organizations; establishing standards for evaluating forms, advertisements, marketing materials, brochures, and discount cards; providing for the collection of data; relating to disclosures to plan members; and defining terms used in this part.

636.005 Incorporation required; exceptions.—
(1) On or after October 1, 1993, any entity that has not yet obtained a certificate of authority to operate a prepaid limited health service organization in this state must be incorporated.
(2) A prepaid limited health service organization may be organized as a profit or nonprofit corporation.
(3) A prepaid limited health service organization may be incorporated in another state if the entity maintains a certificate of authority or license in the state in which it is domiciled to provide services which the applicant intends to provide in this state and maintains a certificate of authority in this state.
(4) This section shall not apply to providers licensed pursuant to chapter 463 or any other licensed professional if incorporation is limited or restricted by law.

636.008 Application for certificate of authority.—Before any entity may operate a prepaid limited health service organization, it must obtain a certificate of authority from the office. An application for a certificate of authority to operate a prepaid limited health service organization must be filed with the office on a form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following:
(1) A copy of the applicant's basic organizational document, including the articles of incorporation, articles of association, partnership agreements, trust agreement, or other applicable documents and all amendments to such documents.
(2) A copy of all bylaws, rules, and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs.
(3) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not

limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the prepaid limited health service organization, including any possible conflicts of interest.

(4) A complete biographical statement, on forms prescribed by the commission, an independent investigation report, and a set of fingerprints, as provided in chapter 624, with respect to each individual identified under subsection (3).

(5) A statement generally describing the applicant, its facilities and personnel, and the limited health service or services to be offered.

(6) A copy of the form of all contracts made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees.

(7) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in subsection (3).

(8) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of limited health services to enrollees.

(9) A copy of the form of any prepaid limited health service contract which is to be issued to employers, unions, trustees, individuals, or other organizations and a copy of any form of evidence of coverage to be issued to subscribers.

(10) A copy of the applicant's most recent financial statements audited by an independent certified public accountant.

(11) A copy of the applicant's financial plan, including a 3-year projection of anticipated operating results, a statement of the sources of funding, and provisions for contingencies, for which projection all material assumptions shall be disclosed.

(12) A schedule of rates and charges for each contract to be used which contains an opinion from a qualified independent actuary or a qualified employee that the rates are not inadequate, excessive, or discriminatory. If a prepaid limited health service organization does not employ or otherwise retain the services of an independent actuary, the chief executive officer of the prepaid limited health service organization must review and sign the certification indicating her or his agreement with its conclusions. If the office determines that, based upon documents filed with the office, the qualified employee is not qualified, the organization shall retain the services of a qualified independent actuary.

(13) A description of the proposed method of marketing.

(14) A description of the subscriber complaint procedures to be established and maintained as required under s. 636.038.

(15) A description of how the applicant will comply with s. 636.046.

(16) The fee for issuance of a certificate of authority as provided in s. 636.057.

(17) Such other information as the commission or office may reasonably require to make the determinations required by this act.

The office shall issue a certificate of authority which shall expire on June 1 each year and which the office shall renew if the applicant pays the license fees provided in s. 636.057 and if the office is satisfied that the organization is in compliance with this act.

636.009 Issuance of certificate of authority; denial.—

(1) Following receipt of an application filed pursuant to s. 636.008, the office shall review such application and notify the applicant of any deficiencies contained therein. The office shall issue a certificate of authority to an applicant who has filed a completed application in

conformity with s. 636.008, upon payment of the fees specified by s. 636.057 and upon the office being satisfied that the following conditions are met:

(a) The requirements of s. 636.008 have been fulfilled.

(b) The entity is actuarially sound.

(c) The entity has met the applicable minimum surplus requirements specified in s. 636.045.

(d) The procedures for offering limited health services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, sex, race, handicap, health, or economic status. However, this paragraph does not prohibit reasonable underwriting classifications for the purposes of establishing contract rates, nor does it prohibit prospective experience rating.

(e) The entity furnished evidence of adequate insurance coverage, including, but not limited to, general liability or professional liability coverage, or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing covered services.

(f) The ownership, control, and management of the entity are competent and trustworthy and possess managerial experience that would make the proposed operation beneficial to the subscribers. The office shall not grant or continue authority to transact the business of a prepaid limited health service organization in this state at any time during which the office has good reason to believe that the ownership, control, or management of the organization includes any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors.

(g) The entity has demonstrated compliance with s. 636.047 by obtaining a blanket fidelity bond in the amount of at least $50,000, issued by a licensed insurance carrier in this state, that will reimburse the entity in the event that anyone handling the funds of the entity either misappropriates or absconds with the funds. All employees handling the funds must be covered by the blanket fidelity bond. However, the fidelity bond need not cover an individual who owns 100 percent of the stock of the organization if such stockholder maintains total control of the organization's financial assets, books and records, and fidelity bond coverage is not available for such individual. An agent licensed under the provisions of the Florida Insurance Code may, either directly or indirectly, represent the prepaid limited health service organization in the solicitation, negotiation, effectuation, procurement, receipt, delivery, or forwarding of any subscriber's contract, or collect or forward any consideration paid by the subscriber to the prepaid limited health service organization. The licensed agent shall not be required to post the bond required by this subsection.

(h) The prepaid limited health service organization has a grievance procedure that will facilitate the resolution of subscriber grievances and that includes both formal and informal steps available within the organization.

(i) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the office may consider:

1. The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments, and other patient charges used in connection therewith.
2. The adequacy of surplus, other sources of funding, and provisions for contingencies.
3. The manner in which the requirements of s. 636.046 have been fulfilled.

(j) The agreements with providers for the provision of limited health services contain the provisions required by s. 636.035.

(k) Any deficiencies identified by the office have been corrected.

(l) All requirements of this chapter have been met.

(2) If the certificate of authority is denied, the office shall notify the applicant and shall specify the reasons for denial in the notice.

636.012 Continued eligibility for certificate of authority.—In order to maintain its eligibility for a certificate of authority, a prepaid limited health service organization must continue to meet all conditions required to be met under this act and the rules adopted thereunder for the initial application for and issuance of its certificate of authority under ss. 636.008 and 636.009.

636.016 Prepaid limited health service contracts.—For any entity licensed prior to October 1, 1993, all subscriber contracts in force at such time shall be in compliance with this section upon renewal of such contract.

(1) Any entity issued a certificate of authority and otherwise in compliance with this act may enter into contracts in this state to provide an agreed-upon set of limited health services to subscribers in exchange for a prepaid per capita sum or a prepaid aggregate fixed sum.

(a) The office shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, if the form:

1. Is in any respect in violation of, or does not comply with, any provision of this act or rule adopted thereunder.
2. Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.
3. Has any title, heading, or other indication of its provisions which is misleading.
4. Is printed or otherwise reproduced in such a manner as to render any material provision of the form substantially illegible.
5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.
6. Charges rates that are determined by the office to be inadequate, excessive, or unfairly discriminatory, or if the rating methodology followed by the prepaid limited health service organization is determined by the office to be inconsistent with the provisions of s. 636.017.

(b) It is not the intent of this subsection to restrict unduly the right to modify rates in the exercise of reasonable business judgment.

(c) All contracts shall be for a minimum period of 12 months, unless the contract holder requests, in writing, a shorter contract period.

(2) Every prepaid limited health service organization shall provide each subscriber a contract, a certificate, membership card, or member handbook which must clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement of any limitations on the services or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract or by any insurer or entity which is underwriting any of the services offered by the prepaid limited health service organization. The contract, certificate, provider listing, or member handbook must also state where and in what manner the health services may be obtained.

(3) The documents provided pursuant to subsection (2) must have a clear and understandable description of the method used by the prepaid limited health service organization for resolving subscriber grievances and, for such documents printed after October 1, 1998, must contain the address of the department and the department's toll-free consumer hotline.

(4) The rate of payment for a prepaid limited health services contract sold on an individual basis must be a part of the contract and must be stated in individual contracts issued to subscribers.

(5) All prepaid limited health service coverage, benefits, or services for a member of the family of the subscriber must, as to such family member's coverage, benefits, or services, provide also that the coverage, benefits, or services applicable for children will be provided

with respect to a preenrolled newborn child of the subscriber, or covered family member of the subscriber, from the moment of birth, or adoption pursuant to chapter 63.

(6) No alteration of any written application for any prepaid limited health services contract may be made by any person other than the applicant without his or her written consent, except that insertions may be made by the prepaid limited health service organization for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(7) No contract may contain any waiver of rights or benefits provided to or available to subscribers under the provisions of any law or rule applicable to prepaid limited health service organizations.

(8) Each document provided pursuant to subsection (2) must state that emergency services, if any, will be provided to subscribers in emergency situations not permitting treatment through the prepaid limited health service organization providers, without prior notification to and approval of the organization. The prepaid limited health services document must contain a definition of emergency services, describe procedures for determination by the prepaid limited health service organization of whether the services qualify for reimbursement as emergency services, and contain specific examples of what does constitute an emergency.

(9)(a) All prepaid limited health services contracts, certificates, and member handbooks must contain the following provision:

"Grace Period: This contract has a (insert number of days, but not less than 10 days) -day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, the contract will stay in force."

(b) Paragraph (a) does not apply to certificates or member handbooks delivered to individual subscribers under a group prepaid limited health services contract when the employer who will hold the contract on behalf of the subscriber group pays the entire premium for the individual subscriber. However, such required provision applies to the group prepaid limited health services contract.

(10) The contract must clearly disclose the intent of the prepaid limited health service organization as to the applicability or nonapplicability of coverage to preexisting conditions. The contract must also disclose what services are excludable.

(11) All prepaid limited health service organization contracts which provide coverage for a member of the family of the subscriber, must, as to such family member's coverage, provide that coverage, benefits, or services applicable for children will be provided with respect to an adopted child of the subscriber, which child is placed in compliance with chapter 63, from the moment of placement in the residence of the subscriber. In the case of a newborn child, coverage begins from the moment of birth if a written agreement to adopt such child has been entered into by the subscriber prior to the birth of the child whether or not such agreement is enforceable. However, coverage for such child is not required if the child is not ultimately adopted by the subscriber in compliance with chapter 63.

(12) Each prepaid limited health service organization shall provide prospective enrollees, upon request, with written information about the terms and conditions of the plan in accordance with subsection (2) to enable prospective enrollees to make informed decisions about accepting a managed-care system of limited health care delivery. All marketing materials printed by the prepaid limited health services organization, after October 1, 1997, must contain a notice in boldfaced type which states that the information required under this section is available to prospective enrollees upon request.

(13) Each prepaid limited health service organization shall make available to all subscribers, upon request, a description of the authorization and referral process for

services or a description of the process used to analyze the qualifications and credentials of providers under contract with the organization.

636.017 Rates and charges.—
(1) The rates charged by any prepaid limited health service organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory. The commission or office may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this section.
(2) In determining whether a rate is in compliance with subsection (1), the office must take into consideration the limited services provided, the method in which the services are provided, and the method of provider payment. This section may not be construed as authorizing the commission to establish by rule minimum loss ratios for prepaid limited health service organizations' rates.

636.018 Changes in rates and benefits; material modifications; addition of limited health services.—
(1)(a) No prepaid limited health services contract, certificate of coverage, application, enrollment form, rider, endorsement, and applicable rates to be charged may be delivered in this state unless the forms and rates have been filed with the office by or on behalf of the prepaid limited health service organization and have been approved by the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form. If a prepaid limited health service organization desires to amend any contract with its subscribers or any certificate or member handbook, or desires to change any rate charged for the contract or to change any basic prepaid limited health services contract, certificate, grievance procedure, or member handbook form, or application form where written application is required and is to be made a part of the contract, or printed amendment, addendum, rider, or endorsement form or form renewal certificate, it must file such changes 30 days prior to the effective date of the proposed change. At least 30 days' written notice must be provided to the subscriber before application of any approved change in rates. In the case of a group enrollee, there may be a contractual agreement with the prepaid limited health service organization to have the contract holder provide the required notice to the individual enrollees of the group. Any proposed change must contain information as required by s. 636.017.
(b) The prepaid limited health service organization's certification must be prepared by an independent actuary or a qualified employee. The chief executive officer of the prepaid limited health service organization must review and sign the certification indicating her or his agreement with its conclusions. Following receipt of notice of any disapproval or withdrawal of approval, no prepaid limited health service organization may issue or use any form disapproved by the office or as to which the office has withdrawn approval.
(2) If such filings are disapproved, the office shall notify the prepaid limited health service organization and shall specify the reasons for disapproval in the notice. The prepaid limited health service organization has 21 days from the date of receipt of notice to request a hearing before the office pursuant to chapter 120.

636.043 Annual, quarterly, and miscellaneous reports.—
(1) Each prepaid limited health service organization must file with the office annually, within 3 months after the end of its fiscal year, a report verified by the oath of at least two officers covering the preceding calendar year. Any organization licensed prior to October 1, 1993, shall not be required to file a financial statement, as required by paragraph (2)(a), based on statutory accounting principles until the first annual report for fiscal years ending after December 31, 1994.
(2) Such report must be on forms prescribed by the commission and must include:

(a)1. A statutory financial statement of the organization prepared in accordance with statutory accounting principles, including its balance sheet, income statement, and statement of changes in cash flow for the preceding year, certified by an independent certified public accountant, or a consolidated audited financial statement of its parent company prepared on the basis of statutory accounting principles, certified by an independent certified public accountant, attached to which must be consolidating financial statements of the parent company, including the prepaid limited health service organization.

2. Any entity subject to this chapter may make written application to the office for approval to file audited financial statements prepared in accordance with generally accepted accounting principles in lieu of statutory financial statements. The office shall approve the application if it finds it to be in the best interest of the subscribers. An application for exemption is required each year and must be filed with the office at least 2 months prior to the end of the fiscal year for which the exemption is being requested.

(b) A list of the names and residence addresses of all persons responsible for the conduct of its affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the prepaid limited health service organization, including any possible conflicts of interest.

(c) The number of prepaid limited health services contracts, issued and outstanding, and the number of prepaid limited health services contracts terminated.

(d) The number and amount of damage claims for medical injury initiated against the prepaid limited health service organization, and if known, any of the providers engaged by it during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim.

(e) An actuarial report certified by a qualified independent actuary or qualified employee that:

1. The prepaid limited health service organization is actuarially sound, which certification shall consider the rates, benefits, and expenses of, and any other funds available for, the payment of obligations of the organization.

2. The rates being charged or to be charged are actuarially adequate to the end of the period for which rates have been guaranteed.

3. Incurred but not reported claims and claims reported but not fully paid have been adequately provided for.

(f) Such other information relating to the performance of the prepaid limited health service organization as is reasonably required by the commission or office.

(3) Every prepaid limited health service organization which fails to file an annual report or quarterly report in the form and within the time required by this section shall forfeit up to $500 for each day for the first 10 days during which the neglect continues and shall forfeit up to $1,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the office to that effect, the organization's authority to enroll new subscribers or to do business in this state ceases while such default continues. The office shall deposit all sums collected by it under this section to the credit of the Insurance Regulatory Trust Fund. The office may not collect more than $50,000 for each report.

(4) Each authorized prepaid limited health service organization must file a quarterly report for each calendar quarter within 45 days after the end of the quarter. The report shall contain:

(a) A financial statement prepared in accordance with statutory accounting principles. Any entity licensed before October 1, 1993, shall not be required to file a financial statement based on statutory accounting principles until the first quarterly filing after the entity files its annual financial statement based on statutory accounting principles as required by subsection (1).

(b) A listing of providers.

(c) Such other information relating to the performance of the prepaid limited health service organization as is reasonably required by the commission or office.

(5) The office may require monthly reports if the financial condition of the prepaid limited health service organization has deteriorated from previous periods or if the financial condition of the organization is such that it may be hazardous to subscribers if not monitored more frequently.
(6) Each authorized prepaid limited health service organization shall retain an independent certified public accountant, hereinafter referred to as "CPA," who agrees by written contract with the prepaid limited health service organization to comply with the provisions of this act. The contract must state that:
(a) The CPA will provide to the prepaid limited health service organization audited statutory financial statements consistent with this act.
(b) Any determination by the CPA that the prepaid limited health service organization does not meet minimum surplus requirements as set forth in this act will be stated by the CPA, in writing, in the audited financial statement.
(c) The completed workpapers and any written communications between the CPA and the prepaid limited health service organization relating to the audit of the prepaid limited health service organization will be made available for review on a visual-inspection-only basis by the office at the offices of the prepaid limited health service organization, at the office, or at any other reasonable place as mutually agreed between the office and the prepaid limited health service organization. The CPA must retain for review the workpapers and written communications for a period of not less than 6 years.

636.204 License required.—
(1) Before doing business in this state as a discount medical plan organization, an entity must be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with chapter 605, part I of chapter 607, chapter 617, chapter 620, or chapter 865, and must be licensed by the office as a discount medical plan organization or be licensed by the office pursuant to chapter 624, part I of this chapter, or chapter 641.
(2) An application for a license to operate as a discount medical plan organization must be filed with the office on a form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following, if applicable:
(a) A copy of the applicant's articles of incorporation or other organizing documents, including all amendments.
(b) A copy of the applicant's bylaws.
(c) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount medical plan organization, including any possible conflicts of interest.
(d) A complete biographical statement, on forms prescribed by the commission, an independent investigation report, and a set of fingerprints, as provided in chapter 624, with respect to each individual identified under paragraph (c).
(e) A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered.
(f) A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members.

(g) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in paragraph (c).
(h) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health services to members.
(i) A copy of the applicant's most recent financial statements audited by an independent certified public accountant. An applicant that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the subsidiary may petition the office to accept, in lieu of the audited financial statement of the applicant, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the applicant required by this part will be met by the parent entity.
(j) A description of the proposed method of marketing.
(k) A description of the subscriber complaint procedures to be established and maintained.
(l) The fee for issuance of a license.
(m) Such other information as the commission or office may reasonably require to make the determinations required by this part.
(3) The office shall issue a license which shall expire 1 year later, and each year on that date thereafter, and which the office shall renew if the licensee pays the annual license fee of $50 and if the office is satisfied that the licensee is in compliance with this part.
(4) Prior to licensure by the office, each discount medical plan organization must establish an Internet website so as to conform to the requirements of s. 636.226.
(5) The license fee under subsection (2) is $50 per year per licensee. All amounts collected shall be deposited into the General Revenue Fund.
(6) Nothing in this part requires a provider who provides discounts to his or her own patients to obtain and maintain a license as a discount medical plan organization.

636.218 Annual reports.—
(1) Each discount medical plan organization must file with the office, within 3 months after the end of each fiscal year, an annual report.
(2) Such reports must be on forms prescribed by the commission and must include:
(a) Audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement, and statement of changes in cash flow for the preceding year. An organization that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the organization may petition the office to accept, in lieu of the audited financial statement of the organization, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the organization required by this part will be met by the parent entity.
(b) If different from the initial application or the last annual report, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the discount medical plan organization, including any possible conflicts of interest.
(c) The number of discount medical plan members in the state.
(d) Such other information relating to the performance of the discount medical plan organization as is reasonably required by the commission or office.
(3) Every discount medical plan organization which fails to file an annual report in the form and within the time required by this section shall forfeit up to $500 for each day for the first

10 days during which the neglect continues and shall forfeit up to $1,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the office to that effect, the organization's authority to enroll new members or to do business in this state ceases while such default continues. The office shall deposit all sums collected by the office under this section to the credit of the Insurance Regulatory Trust Fund. The office may not collect more than $50,000 for each report.

636.220 Minimum capital requirements.—
(1) Each discount medical plan organization must at all times maintain a net worth of at least $150,000.
(2) The office may not issue a license unless the discount medical plan organization has a net worth of at least $150,000.

636.226 Provider name listing.—Each discount medical plan organization must maintain an up-to-date list of the names and addresses of the providers with which it has contracted, on an Internet website page, the address of which shall be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the discount medical plan organization has contracted directly, as well as those who are members of a provider network with which the discount medical plan organization has contracted.

636.228 Marketing of discount medical plans.—
(1) All advertisements, marketing materials, brochures, and discount cards used by marketers must be approved in writing for such use by the discount medical plan organization.
(2) The discount medical plan organization shall have an executed written agreement with a marketer prior to the marketer's marketing, promoting, selling, or distributing the discount medical plan. Such agreement shall prohibit the marketer from using marketing materials, brochures, and discount cards without the approval in writing by the discount medical plan organization. The discount medical plan organization shall be bound by any acts of its marketers, within the scope of the marketers' agency, that do not comply with the provisions of this part.

636.234 Service of process on a discount medical plan organization.—Sections 624.422 and 624.423 apply to a discount medical plan organization as if the discount medical plan organization were an insurer.

636.236 Surety bond or security deposit.—
(1) Each discount medical plan organization licensed pursuant to the provisions of this part must maintain in force a surety bond in its own name in an amount not less than $35,000 to be used at the discretion of the office to protect the financial interests of members who may be adversely affected by the insolvency of a discount medical plan organization. The bond must be issued by an insurance company that is licensed to do business in this state.
(2) In lieu of the bond specified in subsection (1), a licensed discount medical plan organization may deposit and maintain deposited in trust with the department securities eligible for deposit under s. 625.52 having at all times a value of not less than $35,000. If a licensed discount medical plan organization substitutes its deposited securities under this subsection with a surety bond authorized in subsection (1), such deposited securities shall be returned to the discount medical plan organization no later than 45 days following the effective date of the surety bond.

(3) No judgment creditor or other claimant of a discount medical plan organization, other than the office or department, shall have the right to levy upon any of the assets or securities held in this state as a deposit under subsections (1) and (2).

69O-167.012

627.701 Liability of insureds; coinsurance; deductibles.—

(6)(a) It is the intent of the Legislature to encourage the use of higher hurricane deductibles as a means of increasing the effective capacity of the hurricane insurance market in this state and as a means of limiting the impact of rapidly changing hurricane insurance premiums. The Legislature finds that the hurricane deductibles specified in this subsection are reasonable when a property owner has made adequate provision for restoration of the property to its full value after a catastrophic loss.

(b) A personal lines residential insurance policy providing hurricane coverage may, at the mutual option of the insured and insurer, include a secured hurricane deductible as described in paragraph (c) if the applicant presents the insurer a certificate of security as described in paragraph (d). An insurer may not directly or indirectly require a secured deductible under this subsection as a condition of issuing or renewing a policy. A certificate of security is not required with respect to an applicant who owns a 100 percent equity interest in the property.

(c) A secured hurricane deductible must include the substance of the following:

1. The first $500 of any claim, regardless of the peril causing the loss, is fully deductible.

2. With respect to hurricane losses only, the next $5,000 in losses are fully insured, subject only to a copayment requirement of 10 percent.

3. With respect to hurricane losses only, the remainder of the claim is subject to a deductible equal to a specified percentage of the policy dwelling limits in excess of the deductible allowed under former paragraph (3)(a) but no higher than 10 percent of the policy dwelling limits.

4. The insurer agrees to renew the coverage on a guaranteed basis for a period of years after initial issuance of the secured deductible equal to at least 1 year for each 2 percentage points of deductible specified in subparagraph 3. unless the policy is canceled for nonpayment of premium or the insured fails to maintain the certificate of security. Such renewal shall be at the same premium as the initial policy except for premium changes attributable to changes in the value of the property.

(d) The office shall draft and formally propose as a rule the form for the certificate of security. The certificate of security may be issued in any of the following circumstances:

1. A mortgage lender or other financial institution may issue a certificate of security after granting the applicant a line of credit, secured by equity in real property or other reasonable security, which line of credit may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss. In the sole discretion of the mortgage lender or other financial institution, the line of credit may be issued to an applicant on an unsecured basis.

2. A licensed insurance agent may issue a certificate of security after obtaining for an applicant a line of credit, secured by equity in real property or other reasonable security, which line of credit may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss. The Florida Hurricane Catastrophe Fund shall negotiate agreements creating a financing consortium to serve as an additional source of lines of credit to secure deductibles. Any licensed insurance agent may act as the agent of such consortium.

3. Any person qualified to act as a trustee for any purpose may issue a certificate of security secured by a pledge of assets, with the restriction that the assets may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss.

4. Any insurer, including any admitted insurer or any surplus lines insurer, may issue a certificate of security after issuing the applicant a policy of supplemental insurance that will

pay for 100 percent of the deductible portion of insured construction or reconstruction after a hurricane loss.

5. Any other method approved by the office upon finding that such other method provides a similar level of security as the methods specified in this paragraph and that such other method has no negative impact on residential property insurance catastrophic capacity. The legislative intent of this subparagraph is to provide the flexibility needed to achieve the public policy of expanding property insurance capacity while improving the affordability of property insurance.

(e) An issuer of a certificate of security may terminate the certificate for failure to honor any of the terms of the underlying financial arrangement. The issuer must provide notice of termination to the insurer within 10 working days after termination. Unless the policyholder obtains a replacement certificate of security within an additional 20 working days after such notice, the deductible provision in the policy must revert to a lower deductible otherwise offered by the insurer and the policyholder is responsible for any additional premium required for a policy with such deductible.

624.424 Annual statement and other information.—

(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain:

1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the

department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to

by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

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

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of

any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.610 Reinsurance.—
(1) The purpose of this section is to protect the interests of insureds, claimants, ceding insurers, assuming insurers, and the public. It is the intent of the Legislature to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislature requires that upon the insolvency of a non-United States insurer or reinsurer which provides security to fund its United States obligations in accordance with this section, such security shall be maintained in the United States and claims shall be filed with and valued by the state insurance regulator with regulatory oversight, and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies. The Legislature declares that the matters contained in this section are fundamental to the business of insurance in accordance with 15 U.S.C. ss. 1011-1012.
(2) Credit for reinsurance must be allowed a ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of paragraph (3)(a), paragraph (3)(b), or paragraph (3)(c). Credit must be allowed under paragraph (3)(a) or paragraph (3)(b) only for cessions of those kinds or lines of business that the assuming insurer is licensed, authorized, or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed or authorized to transact insurance or reinsurance.
(3)(a) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is authorized to transact insurance or reinsurance in this state.
(b)1. Credit must be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state. An accredited reinsurer is one that:
a. Files with the office evidence of its submission to this state's jurisdiction;
b. Submits to this state's authority to examine its books and records;
c. Is licensed or authorized to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through, licensed, or authorized to transact insurance or reinsurance in at least one state;
d. Files annually with the office a copy of its annual statement filed with the insurance department of its state of domicile any quarterly statements if required by its state of

domicile or such quarterly statements if specifically requested by the office, and a copy of its most recent audited financial statement; and

(I) Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has not been denied by the office within 90 days after its submission; or

(II) Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has been approved by the office.

2. The office may deny or revoke an assuming insurer's accreditation if the assuming insurer does not submit the required documentation pursuant to subparagraph 1., if the assuming insurer fails to meet all of the standards required of an accredited reinsurer, or if the assuming insurer's accreditation would be hazardous to the policyholders of this state. In determining whether to deny or revoke accreditation, the office may consider the qualifications of the assuming insurer with respect to all the following subjects:

a. Its financial stability;

b. The lawfulness and quality of its investments;

c. The competency, character, and integrity of its management;

d. The competency, character, and integrity of persons who own or have a controlling interest in the assuming insurer; and

e. Whether claims under its contracts are promptly and fairly adjusted and are promptly and fairly paid in accordance with the law and the terms of the contracts.

3. Credit must not be allowed a ceding insurer if the assuming insurer's accreditation has been revoked by the office after notice and the opportunity for a hearing.

4. The actual costs and expenses incurred by the office to review a reinsurer's request for accreditation and subsequent reviews must be charged to and collected from the requesting reinsurer. If the reinsurer fails to pay the actual costs and expenses promptly when due, the office may refuse to accredit the reinsurer or may revoke the reinsurer's accreditation.

(c)1. Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in paragraph (5)(b), for the payment of the valid claims of its United States ceding insurers and their assigns and successors in interest. To enable the office to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the office information substantially the same as that required to be reported on the NAIC Annual Statement form by authorized insurers. The assuming insurer shall submit to examination of its books and records by the office and bear the expense of examination.

2.a. Credit for reinsurance must not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:

(I) The insurance regulator of the state in which the trust is domiciled; or

(II) The insurance regulator of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

b. The form of the trust and any trust amendments must be filed with the insurance regulator of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the insurance regulator.

c. The trust remains in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year, the trustee of the trust shall report to the insurance regulator in writing the balance of the trust and list the trust's investments at the preceding year end, and shall certify that the trust will not expire prior to the following December 31.

3. The following requirements apply to the following categories of assuming insurer:

a. The trust fund for a single assuming insurer consists of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20 million. Not less than 50 percent of the funds in the trust covering the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers and trusteed surplus shall consist of assets of a quality substantially similar to that required in part II of chapter 625. Clean, irrevocable, unconditional, and evergreen letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (5)(a), effective no later than December 31 of the year for which the filing is made and in the possession of the trust on or before the filing date of its annual statement, may be used to fund the remainder of the trust and trusteed surplus.

b.(I) In the case of a group including incorporated and individual unincorporated underwriters:

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

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

(C) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which $100 million must be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

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

(III) Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the insurance regulator an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

(d) Credit must be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), paragraph (b), or paragraph (c), but only as to the insurance of risks located in jurisdictions in which the reinsurance is required to be purchased by a particular entity by applicable law or regulation of that jurisdiction.

(e) If the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), paragraph (b), paragraph (c), or paragraph (d), the commissioner may allow credit, but only if the assuming insurer holds surplus in excess of $250 million and has a secure financial strength rating from at least two statistical rating organizations deemed acceptable by the commissioner as having experience and expertise in rating insurers doing business in Florida, including, but not limited to, Standard & Poor's, Moody's Investors Service, Fitch Ratings, A.M. Best Company, and Demotech. In determining whether credit should be allowed, the commissioner shall consider the following:

1. The domiciliary regulatory jurisdiction of the assuming insurer.
2. The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and the financial surveillance of the reinsurer.
3. The substance of financial and operating standards for reinsurers in the domiciliary jurisdiction.
4. The form and substance of financial reports required to be filed by the reinsurers in the domiciliary jurisdiction or other public financial statements filed in accordance with generally accepted accounting principles.

5. The domiciliary regulator's willingness to cooperate with United States regulators in general and the office in particular.
6. The history of performance by reinsurers in the domiciliary jurisdiction.
7. Any documented evidence of substantial problems with the enforcement of valid United States judgments in the domiciliary jurisdiction.
8. Any other matters deemed relevant by the commissioner. The commissioner shall give appropriate consideration to insurer group ratings that may have been issued. The commissioner may, in lieu of granting full credit under this subsection, reduce the amount required to be held in trust under paragraph (c).

(f) If the assuming insurer is not authorized or accredited to transact insurance or reinsurance in this state pursuant to paragraph (a) or paragraph (b), the credit permitted by paragraph (c) or paragraph (d) must not be allowed unless the assuming insurer agrees in the reinsurance agreements:

1.a. That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

b. To designate the Chief Financial Officer, pursuant to s. 48.151, or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding company.

2. This paragraph is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

(g) If the assuming insurer does not meet the requirements of paragraph (a) or paragraph (b), the credit permitted by paragraph (c) or paragraph (d) is not allowed unless the assuming insurer agrees in the trust agreements, in substance, to the following conditions:

1. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by paragraph (c), or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the insurance regulator with regulatory oversight over the trust or with an order of a United States court of competent jurisdiction directing the trustee to transfer to the insurance regulator with regulatory oversight all of the assets of the trust fund.

2. The assets must be distributed by and claims must be filed with and valued by the insurance regulator with regulatory oversight in accordance with the laws of the state in which the trust is domiciled which are applicable to the liquidation of domestic insurance companies.

3. If the insurance regulator with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof must be returned by the insurance regulator with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

4. The grantor shall waive any right otherwise available to it under United States law which is inconsistent with this provision.

(4) An asset allowed or a deduction from liability taken for the reinsurance ceded by an insurer to an assuming insurer not meeting the requirements of subsections (2) and (3) is allowed in an amount not exceeding the liabilities carried by the ceding insurer. The deduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is

held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer, or, in the case of a trust, held in a qualified United States financial institution, as defined in paragraph (5)(b). This security may be in the form of:

(a) Cash in United States dollars;

(b) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets pursuant to part II of chapter 625;

(c) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (5)(a), effective no later than December 31 of the year for which the filing is made, and in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement; or

(d) Any other form of security acceptable to the office.

(5)(a) For purposes of paragraph (4)(c) regarding letters of credit, a "qualified United States financial institution" means an institution that:

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

2. Is regulated, supervised, and examined by United States or state authorities having regulatory authority over banks and trust companies; and

3. Has been determined by either the office or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the office.

(b) For purposes of those provisions of this law which specify institutions that are eligible to act as a fiduciary of a trust, a "qualified United States financial institution" means an institution that is a member of the Federal Reserve System or that has been determined by the office to meet the following criteria:

1. Is organized or, in the case of a United States branch or agency office of a foreign banking organization, is licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

2. Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(6) For the purposes of this section only, the term "ceding insurer" includes any health maintenance organization operating under a certificate of authority issued under part I of chapter 641.

(7) After notice and an opportunity for a hearing, the office may disallow any credit that it finds would be contrary to the proper interests of the policyholders or stockholders of a ceding domestic insurer.

(8) Credit must be allowed to any ceding insurer for reinsurance otherwise complying with this section only when the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer. Such credit must be allowed to the ceding insurer for reinsurance otherwise complying with this section only when the reinsurance agreement provides that payments by the assuming insurer will be made directly to the ceding insurer or its receiver, except when:

(a) The reinsurance contract specifically provides payment to the named insured, assignee, or named beneficiary of the policy issued by the ceding insurer in the event of the insolvency of the ceding insurer; or

(b) The assuming insurer, with the consent of the named insured, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer in substitution for the obligations of the ceding insurer to the named insured.

(9) No person, other than the ceding insurer, has any rights against the reinsurer which are not specifically set forth in the contract of reinsurance or in a specific written, signed agreement between the reinsurer and the person.

(10) An authorized insurer may not knowingly accept as assuming reinsurer any risk covering subject of insurance which is resident, located, or to be performed in this state and which is written directly by any insurer not then authorized to transact such insurance in this state, other than as to surplus lines insurance lawfully written under part VIII of chapter 626.

(11)(a) Any domestic or commercially domiciled insurer ceding directly written risks of loss under this section shall, within 30 days after receipt of a cover note or similar confirmation of coverage, or, without exception, no later than 6 months after the effective date of the reinsurance treaty, file with the office one copy of a summary statement containing the following information about each treaty:

1. The contract period;
2. The nature of the reinsured's business;
3. An indication as to whether the treaty is proportional, nonproportional, coinsurance, modified coinsurance, or indemnity, as applicable;
4. The ceding company's loss retention per risk;
5. The reinsured limits;
6. Any special contract restrictions;
7. A schedule of reinsurers assuming the risks of loss;
8. An indication as to whether payments to the assuming insurer are based on written premiums or earned premiums;
9. Identification of any intermediary or broker used in obtaining the reinsurance and the commission paid to such intermediary or broker if known; and
10. Ceding commissions and allowances.

(b) The summary statement must be signed and attested to by either the chief executive officer or the chief financial officer of the reporting insurer. In addition to the summary statement, the office may require the filing of any supporting information relating to the ceding of such risks as it deems necessary. If the summary statement prepared by the ceding insurer discloses that the net effect of a reinsurance treaty or treaties (or series of treaties with one or more affiliated reinsurers entered into for the purpose of avoiding the following threshold amount) at any time results in an increase of more than 25 percent to the insurer's surplus as to policyholders, then the insurer shall certify in writing to the office that the relevant reinsurance treaty or treaties comply with the accounting requirements contained in any rule adopted by the commission under subsection (14). If such certificate is filed after the summary statement of such reinsurance treaty or treaties, the insurer shall refile the summary statement with the certificate. In any event, the certificate must state that a copy of the certificate was sent to the reinsurer under the reinsurance treaty.

(c) This subsection applies to cessions of directly written risk or loss. This subsection does not apply to contracts of facultative reinsurance or to any ceding insurer that has a surplus as to policyholders which exceeds $100 million as of the immediately preceding December 31. A ceding insurer otherwise subject to this section which had less than $500,000 in direct premiums written in this state during the preceding calendar year and no more than $250,000 in direct premiums written in this state during the preceding calendar quarter, and which had fewer than 1,000 policyholders at the end of the preceding calendar year, is exempt from this subsection.

(d) An authorized insurer not otherwise exempt from the provisions of this subsection shall provide the information required by this subsection with underlying and supporting documentation upon written request of the office.

(e) The office may, upon a showing of good cause, waive the requirements of this subsection.

(12) If the office finds that a reinsurance agreement creates a substantial risk of insolvency to either insurer entering into the reinsurance agreement, the office may by order require a cancellation of the reinsurance agreement.

(13) No credit shall be allowed for reinsurance with regard to which the reinsurance agreement does not create a meaningful transfer of risk of loss to the reinsurer.
(14) The commission may adopt rules implementing the provisions of this section. Rules are authorized to protect the interests of insureds, claimants, ceding insurers, assuming insurers, and the public. These rules shall be in substantial compliance with:
(a) The National Association of Insurance Commissioners model regulations relating to credit for reinsurance;
(b) The National Association of Insurance Commissioners Accounting Practices and Procedures Manual as of March 2002 and subsequent amendments thereto if the methodology remains substantially consistent; and
(c) The National Association of Insurance Commissioners model regulation for Credit for Reinsurance and Life and Health Reinsurance Agreements.

The commission may further adopt rules to provide for transition from existing requirements for the approval of reinsurers to the accreditation of reinsurers pursuant to this section.

(15) Any reinsurer approved pursuant to s. 624.610(3)(a)2., as such provision existed prior to July 1, 2000, which fails to obtain accreditation pursuant to this section prior to December 30, 2003, shall have its approval terminated by operation of law on that date.
(16) This act shall apply to all cessions on or after January 1, 2001, under reinsurance agreements that have an inception, anniversary, or renewal date on or after January 1, 2001.

69O-143

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

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

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of

any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.317 Investigation of agents, adjusters, administrators, service companies, and others.—If it has reason to believe that any person has violated or is violating any provision of this code, or upon the written complaint signed by any interested person indicating that any such violation may exist:
(1) The department shall conduct such investigation as it deems necessary of the accounts, records, documents, and transactions pertaining to or affecting the insurance affairs of any general agent, surplus lines agent, adjuster, managing general agent, insurance agent, insurance agency, customer representative, service representative, or other person subject to its jurisdiction, subject to the requirements of s. 626.601.
(2) The office shall conduct such investigation as it deems necessary of the accounts, records, documents, and transactions pertaining to or affecting the insurance affairs of any:
(a) Administrator, service company, or other person subject to its jurisdiction.
(b) Person having a contract or power of attorney under which she or he enjoys in fact the exclusive or dominant right to manage or control an insurer.
(c) Person engaged in or proposing to be engaged in the promotion or formation of:
1. A domestic insurer;
2. An insurance holding corporation; or
3. A corporation to finance a domestic insurer or in the production of the domestic insurer's business.

625.82 Rules.—The commission may adopt such rules as are necessary for the execution of the functions vested in it by ss. 625.75-625.81 and may for such purpose classify domestic stock insurers, securities, and other persons or matters within its jurisdiction. No provision of ss. 625.75-625.77 imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule of the commission, notwithstanding that such rule may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

625.76 Preventing unfair use of information; insurer to recover profit by suit.—
(1) Any profit realized by a person required to report pursuant to s. 625.75 from any purchase and sale, or sale and purchase, within a period of less than 6 months, of any

equity security of an insurer named in such report shall inure to and be recoverable by the insurer, unless such security was acquired in good faith in connection with a debt contracted prior to the establishment of the relationship to the insurer reported under s. 625.75.
(2) Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the insurer, or by the owner of any security of the insurer in the name and in behalf of the insurer if the insurer fails or refuses to bring such suit within 60 days after request or fails diligently to prosecute the same thereafter.
(3) This section shall not be construed to cover any transaction by a person who was not required both at the time of purchase and of sale to comply with s. 625.75.

625.55 Custodial arrangements.—
(1) In lieu of a deposit being made with it in fact, the department in its discretion may permit or require that the deposit be made with and held by the trust department of a national bank organized and existing under the laws of the United States Government or a state bank or savings and loan organized and existing under the laws of this state, provided that the national or state bank or the savings and loan is approved by the department for this purpose and under custodial arrangements likewise approved by the department, which arrangements may include the use of the Federal Reserve book-entry system or depository trust clearing systems established to hold and transfer securities by computerized book-entry systems.
(2) All such custodial arrangements shall comply in substance with the requirements of this code as to like deposits with the department of other insurers; as to the amount, purposes, maintenance, replenishment, release, and withdrawal of such deposits or part thereof; as to the rights of the insurer therein; and in all other respects except as to actual custody.
(3) The form and terms of all such custodial agreements shall be as prescribed or approved by the department consistent with the applicable provisions of this code.
(4) The compensation and expenses of any such custodian shall be borne by the insurer.
(5) The department or office may at any time, in its discretion, terminate any such custodial arrangement and require the deposit represented thereby to be made with it directly as otherwise provided for under this code.

628.511 Ownership or transfer of securities without physical delivery of certificates.—
(1) The purpose of this section is to authorize domestic insurers to use modern systems for holding and transferring securities without physical delivery of securities certificates, subject to appropriate rules of the commission.
(2) The following terms are defined for use in this section:
(a) "Securities" means instruments as defined in s. 678.1021.
(b) "Clearing corporation" means a clearing corporation as defined in s. 678.1021 and includes the Treasury/Reserve Automated Debt Entry System or Treasury Direct book-entry securities systems as established pursuant to 31 U.S.C. chapter 31, 12 U.S.C. s. 391, and 5 U.S.C. s. 301.
(c) "Custodian" means a national bank, state bank, trust company, broker, or dealer that participates in a clearing corporation.
(3) Notwithstanding any other provision of law, a domestic insurer may deposit or arrange for the deposit of securities held in or purchased for its general account and its separate accounts in a clearing corporation. When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of such clearing corporation with any other securities deposited with such clearing corporation by any person, regardless of the ownership of such securities, and certificates representing securities of small denominations may be merged into one or more certificates of larger denominations. The records of any

custodian through which an insurer holds securities in a clearing corporation shall at all times show that such securities are held for such insurer and for which accounts thereof. Ownership of, and other interests in, such securities may be transferred by bookkeeping entry on the books of such clearing corporation without physical delivery of certificates representing such securities.
(4) The commission may adopt rules governing the deposit by insurers of securities with clearing corporations.

628.535 Authority to adopt rules.—The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter.

628.801 Insurance holding companies; registration; regulation.—
(1) An insurer that is authorized to do business in this state and that is a member of an insurance holding company shall, on or before April 1 of each year, register with the office and file a registration statement and be subject to regulation with respect to its relationship to the holding company as provided by law or rule. The commission shall adopt rules establishing the information and statement form required for registration and the manner in which registered insurers and their affiliates are regulated. The rules apply to domestic insurers, foreign insurers, and commercially domiciled insurers, except for foreign insurers domiciled in states that are currently accredited by the NAIC. Except to the extent of any conflict with this code, the rules must include all requirements and standards of ss. 4 and 5 of the Insurance Holding Company System Regulatory Act and the Insurance Holding Company System Model Regulation of the NAIC, as adopted in December 2010. The commission may adopt subsequent amendments thereto if the methodology remains substantially consistent. The rules may include a prohibition on oral contracts between affiliated entities. Material transactions between an insurer and its affiliates shall be filed with the office as provided by rule.
(2) Effective January 1, 2015, the ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report on or before April 1. As used in this subsection, the term "ultimate controlling person" means a person who is not controlled by any other person. The report, to the best of the ultimate controlling person's knowledge and belief, must identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state office of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC and is confidential and exempt from public disclosure as provided in s. 624.4212.
(a) An insurer may satisfy this requirement by providing the office with the most recently filed parent corporation reports that have been filed with the Securities and Exchange Commission which provide the appropriate enterprise risk information.
(b) The term "enterprise risk" means an activity, circumstance, event, or series of events involving one or more affiliates of an insurer which, if not remedied promptly, are likely to have a materially adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including anything that would cause the insurer's risk-based capital to fall into company action level as set forth in s. 624.4085 or would cause the insurer to be in a hazardous financial condition.
(3) Effective January 1, 2015, pursuant to chapter 624 relating to the examination of insurers, the office may examine any insurer registered under this section and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.
(4) The filings and related documents filed pursuant to this section are confidential and exempt as provided in s. 624.4212 and are not subject to subpoena or discovery directly

from the office. A waiver of any applicable privilege or claim of confidentiality in the filings and related documents may not occur as a result of any disclosure to the office under this section or any other section of the insurance code as authorized under s. 624.4212. Neither the office nor any person who received the filings and related documents while acting under the authority of the office or with whom such information is shared pursuant to s. 624.4212 is permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to s. 624.4212. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office.

(5) Effective January 1, 2015, the failure to file a registration statement, or a summary of the registration statement, or the enterprise risk filing report required by this section within the time specified for filing is a violation of this section.

(6) Upon request, the office may waive the filing requirements of this section:

(a) If the insurer is a domestic insurer that is the subsidiary of an insurer that is in full compliance with the insurance holding company registration laws of its state of domicile, which state is accredited by the NAIC; or

(b) If the insurer is a domestic insurer that writes only in this state and has annual direct written and assumed premium of less than $300 million, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, and demonstrates that compliance with this section would not provide substantial regulatory or consumer benefit. In evaluating a waiver request made under this paragraph, the office may consider various factors including, but not limited to, the type of business entity, the volume of business written, the ownership or organizational structure of the entity, or whether the company is in runoff.

A waiver granted pursuant to this subsection is valid for 2 years unless sooner withdrawn due to a change in the circumstances under which the waiver was granted.

628.152 Domestic stock insurers; proxies, consents, and authorizations with respect to any voting security.—

(1) The commission may, by rule, prescribe the form, content, and manner of solicitation of any proxy, consent, or authorization with respect to any voting security issued by a domestic stock insurer, as may be necessary or appropriate in the public interest or for the proper protection of investors in the voting securities issued by such insurer or to ensure the fair dealing in such voting securities.

(2) No person and no domestic stock insurer or any director, officer, or employee of such insurer shall solicit or permit the use of his or her name to solicit, by mail or otherwise, any person to give any proxy, consent, or authorization with respect to any voting security in contravention of any such rule.

(3) Any proxy or consent obtained in violation of this section is void. The domestic stock insurer, any stockholder of record, or the office may enforce compliance with this section, by an appropriate civil action.

(4) This section shall not apply to voting securities registered pursuant to s. 12 of the Securities Exchange Act of 1934, as amended.

(5) "Voting security" means any instrument which, in law or by contract, gives the holder the right to vote, consent to, or authorize any corporate action.

628.251 Management and exclusive agency contracts.—

(1) No domestic mutual insurer or stock insurer shall make any contract whereby any person is granted or is to enjoy in fact the management of the insurer to the substantial exclusion of its board of directors or to have the controlling or preemptive right to produce

substantially all insurance business for the insurer, unless the contract is filed with and approved by the office.
(2) Any such contract shall provide that any such manager or producer of its business shall within 90 days after expiration of each calendar year furnish the insurer's board of directors a written statement of amounts received under or on account of the contract and amounts expended thereunder during such calendar year, including the emoluments received therefrom by the respective directors, officers, and other principal management personnel of the manager or producer, and with such classification of items and further detail as the insurer's board of directors may reasonably require.
(3) The office shall disapprove any such contract if it finds that it:
(a) Subjects the insurer to excessive charges;
(b) Is to extend for an unreasonable length of time;
(c) Does not contain fair and adequate standards of performance; or
(d) Contains other inequitable provision or provisions which impair the proper interests of policyholders or members of the insurer.

628.371 Dividends to stockholders.—
(1) A domestic stock insurer shall not pay any dividend or distribute cash or other property to stockholders except out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and net realized capital gains.
(2) Dividend payments or distributions to stockholders, without prior written approval of the office, shall not exceed the larger of:
(a) The lesser of 10 percent of surplus or net gain from operations (life and health companies) or net income (property and casualty companies), not including realized capital gains, plus a 2-year carryforward for property and casualty companies;
(b) Ten percent of surplus, with dividends payable constrained to unassigned funds minus 25 percent of unrealized capital gains;
(c) The lesser of 10 percent of surplus or net investment income (net gain before capital gains for life and health companies) plus a 3-year carryforward (2-year carryforward for life and health companies) with dividends payable constrained to unassigned funds minus 25 percent of unrealized capital gains.
(3) In lieu of the provisions in subsection (2), an insurer may pay a dividend or make a distribution without the prior written approval of the office when:
(a) The dividend is equal to or less than the greater of:
1. Ten percent of the insurer's surplus as to policyholders derived from realized net operating profits on its business and net realized capital gains; or
2. The insurer's entire net operating profits and realized net capital gains derived during the immediately preceding calendar year; and
(b) The insurer will have surplus as to policyholders equal to or exceeding 115 percent of the minimum required statutory surplus as to policyholders after the dividend or distribution is made; and
(c) The insurer has filed notice with the office at least 10 business days prior to the dividend payment or distribution, or such shorter period of time as approved by the office on a case-by-case basis. Such notice shall not create a right in the office to approve or disapprove a dividend otherwise properly payable hereunder; and
(d) The notice includes a certification by an officer of the insurer attesting that after payment of the dividend or distribution the insurer will have at least 115 percent of required statutory surplus as to policyholders.
(4) The office shall not approve a dividend or distribution in excess of the maximum amount allowed in subsection (1) unless, considering the following factors, it determines that the distribution or dividend would not jeopardize the financial condition of the insurer:
(a) The liquidity, quality, and diversification of the insurer's assets and the effect on its ability to meet its obligations.

(b) Reduction of investment portfolio and investment income.
(c) Effects on the written premium to surplus ratios as required by the Florida Insurance Code.
(d) Industrywide financial conditions.
(e) Prior dividend distributions of the insurer.
(f) Whether the dividend is only a "pass-through" dividend from a subsidiary of the insurer.
(5) A dividend or distribution by a not-for-profit insurance company subsidiary to its mutual insurance holding company, directly or indirectly through one or more intermediate holding companies, pursuant to part III of this chapter, which meets the requirements of this section and which applies to a stock insurer, is permitted under this section.

628.381 Dividends to mutual policyholders.—
(1) The directors of a domestic mutual insurer may from time to time apportion and pay or credit to its members dividends only out of that part of its surplus funds which represents net realized savings and net realized earnings in excess of the surplus required by law to be maintained.
(2) A dividend otherwise proper may be payable out of such savings and earnings even though the insurer's total surplus is then less than the aggregate of its contributed surplus.

628.461 Acquisition of controlling stock.—
(1) A person may not, individually or in conjunction with any affiliated person of such person, acquire directly or indirectly, conclude a tender offer or exchange offer for, enter into any agreement to exchange securities for, or otherwise finally acquire 10 percent or more of the outstanding voting securities of a domestic stock insurer or of a controlling company, unless:
(a) The person or affiliated person has filed with the office and sent to the insurer and controlling company a letter of notification regarding the transaction or proposed transaction within 5 days after any form of tender offer or exchange offer is proposed, or within 5 days after the acquisition of the securities if no tender offer or exchange offer is involved. The notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;
(b) The person or affiliated person has filed with the office the statement as specified in subsection (3). The statement must be completed and filed within 30 days after:
1. Any definitive acquisition agreement is entered;
2. Any form of tender offer or exchange offer is proposed; or
3. The acquisition of the securities, if no definitive acquisition agreement, tender offer, or exchange offer is involved; and
(c) The office has approved the tender or exchange offer, or acquisition if no tender offer or exchange offer is involved, and approval is in effect.

A filing required under this subsection must be made for any acquisition that equals or exceeds 10 percent of the outstanding voting securities.

(2) This section does not apply to any acquisition of voting securities of a domestic stock insurer or of a controlling company by any person who, on July 1, 1976, is the owner of a majority of such voting securities or who, on or after July 1, 1976, becomes the owner of a majority of such voting securities with the approval of the office under this section. The person or affiliated person filing the notice required by paragraph (1)(a) may request, in writing, the office to waive the requirements of paragraph (1)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the insurer.

The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the insurer.
(3) The statement to be filed with the office under subsection (1) and furnished to the insurer and controlling company must contain all the following information and any additional information that the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the policyholders and shareholders of the insurer and the public:
(a) The identity of, and the background information specified in subsection (4) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and, if the acquisition is to be made by, or on behalf of, a corporation, association, or trust, as to the corporation, association, or trust and as to any person who controls, directly or indirectly, the corporation, association, or trust, the identity of, and the background information specified in subsection (4) on, each director, officer, trustee, or other natural person performing duties similar to those of a director, officer, or trustee for the corporation, association, or trust.
(b) The source and amount of the funds or other consideration used, or to be used, in making the acquisition.
(c) Any plans or proposals that such persons may have made to liquidate such insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management; and any plans or proposals that such persons may have made to liquidate any controlling company of such insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management.
(d) The number of shares or other securities that the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the securities are to be acquired.
(e) Information as to any contract, arrangement, or understanding with any party with respect to any of the securities of the insurer or controlling company, including, but not limited to, information relating to the transfer of any of the securities, option arrangements, puts or calls, or the giving or withholding of proxies, which information names the party with whom the contract, arrangement, or understanding has been entered into and gives the details thereof.
(f) Effective January 1, 2015, an agreement by the person required to file the statement that the person will provide the annual report specified in s. 628.801(2) if control exists.
(g) Effective January 1, 2015, an acknowledgment by the person required to file the statement that the person and all subsidiaries within the person's control in the insurance holding company system will provide, as necessary, information to the office upon request to evaluate enterprise risk to the insurer.
(4)(a) The information as to the background and identity of each person, which information is required to be furnished pursuant to paragraph (3)(a), shall include:
1. The person's occupations, positions of employment, and offices held during the past 10 years.
2. The principal business and address of any business, corporation, or other organization in which each such office of the person was held or in which each such occupation or position of employment was carried on.
3. Whether the person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.
4. Whether the person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.
5. Whether, during the 10-year period, the person has been the subject of any proceeding under the federal [1]Bankruptcy Act or whether, during the 10-year period, any corporation,

partnership, firm, trust, or association in which the person was a director, officer, trustee, partner, or other official has been subject to any such proceeding, either during the time in which the person was a director, officer, trustee, partner, or other official or within 12 months thereafter.

6. Whether, during the 10-year period, the person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law regulating the business of insurance, securities, or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities, or banking, together with details as to any such event.

(b) Any corporation, association, or trust filing the statement required by this section shall give all required information that is within the knowledge of the directors, officers, or trustees (or others performing functions similar to those of a director, officer, or trustee) of the corporation, association, or trust making the filing and of any person controlling either directly or indirectly such corporation, association, or trust. A copy of the statement and any amendments to the statement shall be sent by registered mail to the insurer at its principal office within the state and to any controlling company at its principal office. If any material change occurs in the facts set forth in the statement filed with the office and sent to such insurer or controlling company pursuant to this section, an amendment setting forth such changes shall be filed immediately with the office and sent immediately to such insurer and controlling company.

(5)(a) The acquisition of voting securities shall be deemed approved unless the office disapproves the proposed acquisition within 90 days after the statement required by subsection (1) has been filed. The office may on its own initiate, or if requested to do so in writing by a substantially affected party shall conduct, a proceeding to consider the appropriateness of the proposed filing. The 90-day time period shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10 days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time that it finds an immediate danger to the public health, safety, and welfare of the domestic policyholders exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition temporarily disapproved and any further steps to conclude the acquisition ceased.

(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the insurer unless advance written notice of the change in management is furnished to the office. A material change in the operation of the insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the insurer. A material change in the management of the insurer is any change in management involving officers or directors of the insurer or any person of the insurer or controlling company having authority to dispose of or obligate 5 percent or more of the insurer's capital or surplus. The office shall approve a material change in operation if it finds the applicable provisions of subsection (7) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (7) have not been met and in such case the insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(6) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:
(a) Willfully violates this section;
(b) In violation of an order of the office issued pursuant to subsection (10), fails to divest himself or herself of any stock obtained in violation of this section, or fails to divest himself or herself of any direct or indirect control of such stock, within 25 days after such order; or
(c) In violation of an order issued by the office pursuant to subsection (10), acquires additional stock of the domestic insurance company or controlling company, or direct or indirect control of such stock, without complying with this section.
(7) The person or persons filing the statement required by subsection (1) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed statement if no proceeding is conducted, that:
(a) Upon completion of the acquisition, the domestic stock insurer will be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;
(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the insurer or prejudice the interests of its policyholders or the public;
(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:
1. To liquidate the insurer, sell its assets, or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management; or
2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the insurer

is fair and free of prejudice to the policyholders of the domestic stock insurer or to the public;

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the domestic stock insurer indicate that the acquisition is in the best interest of the policyholders of the insurer and in the public interest;
(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the policyholders of the domestic stock insurer, and in the public interest, to permit such persons to exercise control over such domestic stock insurer;
(f) The officers and directors to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation;
(g) The management of the insurer after the acquisition will be competent and trustworthy and will possess sufficient managerial experience so as to make the proposed operation of the insurer not hazardous to the insurance-buying public;
(h) The management of the insurer after the acquisition will not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto;
(i) The acquisition is not likely to be hazardous or prejudicial to the insurer's policyholders or the public; and
(j) The effect of the acquisition of control would not substantially lessen competition in insurance in this state or would not tend to create a monopoly therein.
(8) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition of any security contrary to the provisions of this section is void. Upon the petition of the domestic stock insurer or controlling company, the circuit court for the county in which the principal office of such domestic stock insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the

provisions of this section. There shall be a private right of action in favor of the domestic stock insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the domestic stock insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by such domestic stock insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of a statement pursuant to this section, or who files such a statement, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section, and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.

(9) Any approval by the office under this section does not constitute a recommendation by the office for an acquisition, tender offer, or exchange offer. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.

(10) Upon notification to the office by the domestic stock insurer or a controlling company that any person or any affiliated person of such person has acquired 10 percent or more of the outstanding voting securities of the domestic stock insurer or controlling company without complying with the provisions of this section, the office shall order that the person and any affiliated person of such person cease acquisition of any further securities of the domestic stock insurer or controlling company; however, the person or any affiliated person of such person may request a proceeding, which proceeding shall be convened within 7 days after the rendering of the order for the sole purpose of determining whether the person, individually or in connection with any affiliated person of such person, has acquired 10 percent or more of the outstanding voting securities of a domestic stock insurer or controlling company. Upon the failure of the person or affiliated person to request a hearing within 7 days, or upon a determination at a hearing convened pursuant to this subsection that the person or affiliated person has acquired voting securities of a domestic stock insurer or controlling company in violation of this section, the office may order the person and affiliated person to divest themselves of any voting securities so acquired.

(11)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any insurer or controlling company:

1. The control of which is acquired in violation of this section;
2. That is controlled, directly or indirectly, by any person or any affiliated person of such person who, in violation of this section, has obtained control of a domestic stock insurer or controlling company; or
3. That is controlled, directly or indirectly, by any person who, directly or indirectly, controls any other person who, in violation of this section, acquires control of a domestic stock insurer or controlling company.

(b) If any insurer is subject to suspension or revocation pursuant to paragraph (a), the insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its policyholders, creditors, or stockholders or to the public.

(12)(a) A person may rebut a presumption of control by filing a disclaimer of control with the office on a form prescribed by the office. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. In lieu of such form, a person or acquiring party may file with the office a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to rules 13d-1(b) or 13d-1(c) under the Securities Exchange Act of 1934, as

amended. After a disclaimer has been filed, the insurer is relieved of any duty to register or report under this section which may arise out of the insurer's relationship with the person unless the office disallows the disclaimer.
(b) A controlling person of a domestic insurer who seeks to divest the person's controlling interest in the domestic insurer in any manner shall file with the office, with a copy provided to the insurer, confidential notice, not subject to public inspection as provided under s. 624.4212, of the person's proposed divestiture at least 30 days before the cessation of control. The office shall determine those instances in which the party seeking to divest or to acquire a controlling interest in an insurer must file for and obtain approval of the transaction. The information remains confidential until the conclusion of the transaction unless the office, in its discretion, determines that confidential treatment interferes with enforcement of this section. If the statement referred to in subsection (1) is otherwise filed, this paragraph does not apply.
(13) The commission may adopt rules that are necessary to administer this section.

628.801 Insurance holding companies; registration; regulation.—
(1) An insurer that is authorized to do business in this state and that is a member of an insurance holding company shall, on or before April 1 of each year, register with the office and file a registration statement and be subject to regulation with respect to its relationship to the holding company as provided by law or rule. The commission shall adopt rules establishing the information and statement form required for registration and the manner in which registered insurers and their affiliates are regulated. The rules apply to domestic insurers, foreign insurers, and commercially domiciled insurers, except for foreign insurers domiciled in states that are currently accredited by the NAIC. Except to the extent of any conflict with this code, the rules must include all requirements and standards of ss. 4 and 5 of the Insurance Holding Company System Regulatory Act and the Insurance Holding Company System Model Regulation of the NAIC, as adopted in December 2010. The commission may adopt subsequent amendments thereto if the methodology remains substantially consistent. The rules may include a prohibition on oral contracts between affiliated entities. Material transactions between an insurer and its affiliates shall be filed with the office as provided by rule.
(2) Effective January 1, 2015, the ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report on or before April 1. As used in this subsection, the term "ultimate controlling person" means a person who is not controlled by any other person. The report, to the best of the ultimate controlling person's knowledge and belief, must identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state office of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC and is confidential and exempt from public disclosure as provided in s. 624.4212.
(a) An insurer may satisfy this requirement by providing the office with the most recently filed parent corporation reports that have been filed with the Securities and Exchange Commission which provide the appropriate enterprise risk information.
(b) The term "enterprise risk" means an activity, circumstance, event, or series of events involving one or more affiliates of an insurer which, if not remedied promptly, are likely to have a materially adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including anything that would cause the insurer's risk-based capital to fall into company action level as set forth in s. 624.4085 or would cause the insurer to be in a hazardous financial condition.
(3) Effective January 1, 2015, pursuant to chapter 624 relating to the examination of insurers, the office may examine any insurer registered under this section and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the

insurance holding company system, or by the insurance holding company system on a consolidated basis.
(4) The filings and related documents filed pursuant to this section are confidential and exempt as provided in s. 624.4212 and are not subject to subpoena or discovery directly from the office. A waiver of any applicable privilege or claim of confidentiality in the filings and related documents may not occur as a result of any disclosure to the office under this section or any other section of the insurance code as authorized under s. 624.4212. Neither the office nor any person who received the filings and related documents while acting under the authority of the office or with whom such information is shared pursuant to s. 624.4212 is permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to s. 624.4212. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office.
(5) Effective January 1, 2015, the failure to file a registration statement, or a summary of the registration statement, or the enterprise risk filing report required by this section within the time specified for filing is a violation of this section.
(6) Upon request, the office may waive the filing requirements of this section:
(a) If the insurer is a domestic insurer that is the subsidiary of an insurer that is in full compliance with the insurance holding company registration laws of its state of domicile, which state is accredited by the NAIC; or
(b) If the insurer is a domestic insurer that writes only in this state and has annual direct written and assumed premium of less than $300 million, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, and demonstrates that compliance with this section would not provide substantial regulatory or consumer benefit. In evaluating a waiver request made under this paragraph, the office may consider various factors including, but not limited to, the type of business entity, the volume of business written, the ownership or organizational structure of the entity, or whether the company is in runoff.
A waiver granted pursuant to this subsection is valid for 2 years unless sooner withdrawn due to a change in the circumstances under which the waiver was granted.

628.803 Sanctions.—
[1](1) Any company failing, without just cause, to file any registration statement or certificate of exemption required to be filed pursuant to commission rules relating to this part or to submit an ORSA summary report or a corporate governance annual disclosure required pursuant to s. 628.8015 shall, in addition to other penalties prescribed under the Florida Insurance Code, be subject to pay a penalty of $100 for each day's delay, not to exceed a total of $10,000.
(2) Every director or officer of an insurance holding company system who knowingly violates or participates in, or who knowingly directs any of the officers or agents of the company to engage in transactions or make investments which have not been properly filed or approved or which violate commission rules relating to this part, shall pay, in their individual capacity, a civil forfeiture of not more than $5,000 per violation. In determining the amount of the civil forfeiture, the office shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, and the history of previous violations.
(3) Whenever it appears to the office that any insurer subject to this part or any director, officer, employee, or agent thereof has engaged in any transaction or entered into a contract which violates commission rules relating to this part, the office may order the insurer to cease and desist immediately any further activity under that transaction or contract. The office may also order the insurer to void any such transaction or contract and

restore the status quo if this action is in the best interest of the policyholders, creditors, or public.

(4) If the office determines that any person violated s. 628.461, s. 628.801, or s. 628.8015, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with part VI of chapter 624.

(5) Any officer, director, or employee of an insurance holding company system who willfully and knowingly subscribes to, or makes or causes to be made, any false statements, false reports, or false filings with the intent to deceive the office in the performance of its duties under this part is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

69O-142 Rulemaking Authority

624.308 Rules.—

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

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

627.7019 Standardization of requirements applicable to insurers after natural disasters.—

(1) The commission shall adopt by rule, pursuant to s. 120.54(1)-(3), standardized requirements that may be applied to insurers as a consequence of a hurricane or other natural disaster. The rules shall address the following areas:

(a) Claims reporting requirements.

(b) Grace periods for payment of premiums and performance of other duties by insureds.

(c) Temporary postponement of cancellations and nonrenewals.

(2) The rules adopted under this section shall require the office to issue an order within 72 hours after the occurrence of a hurricane or other natural disaster specifying, by line of insurance, which of the standardized requirements apply, the geographic areas in which they apply, the time at which applicability commences, and the time at which applicability terminates.

(3) Any emergency rule adopted under s. 120.54(4) which is in conflict with any provision of the rules adopted under this section must be by unanimous vote of the commission.

624.307 General powers; duties.—

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

624.424 Annual statement and other information.—

(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial

statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain:

1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The

audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of

business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.

(f) Number of new policies written.

(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:

1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).

2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.

3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.319 Examination and investigation reports.—

(1) The department or office or its examiner shall make a full and true written report of each examination. The examination report shall contain only information obtained from examination of the records, accounts, files, and documents of or relative to the insurer examined or from testimony of individuals under oath, together with relevant conclusions and recommendations of the examiner based thereon. The department or office shall furnish a copy of the examination report to the insurer examined not less than 30 days prior to filing the examination report in its office. If such insurer so requests in writing within such 30-day period, the department or office shall grant a hearing with

respect to the examination report and shall not so file the examination report until after the hearing and after such modifications have been made therein as the department or office deems proper.

(2) The examination report so filed is admissible in evidence in any action or proceeding brought by the department or office against the person examined, or against its officers, employees, or agents. In all other proceedings, the admissibility of the examination report is governed by the evidence code. The department or office or its examiners may testify and offer other proper evidence as to information secured or matters discovered during the course of an examination, regardless of whether a written report of the examination has been made, furnished, or filed in the department or office. The production of documents during the course of an examination or investigation does not constitute a waiver of the attorney-client or work-product privilege.

(3)(a)1. Examination reports, until filed, are confidential and exempt from s. 119.07(1).

2. Investigation reports are confidential and exempt from s. 119.07(1) until the investigation is completed or ceases to be active.

3. For purposes of this subsection, an investigation is active while it is being conducted by the department or office with a reasonable, good faith belief that it could lead to the filing of administrative, civil, or criminal proceedings. An investigation does not cease to be active if the department or office is proceeding with reasonable dispatch and has a good faith belief that action could be initiated by the department or office or other administrative or law enforcement agency. After an investigation is completed or ceases to be active, portions of the investigation report relating to the investigation remain confidential and exempt from s. 119.07(1) if disclosure would:

a. Jeopardize the integrity of another active investigation;

b. Impair the safety and financial soundness of the licensee or affiliated party;

c. Reveal personal financial information;

d. Reveal the identity of a confidential source;

e. Defame or cause unwarranted damage to the good name or reputation of an individual or jeopardize the safety of an individual; or

f. Reveal investigative techniques or procedures.

(b)1. For purposes of this paragraph, "work papers" means the records of the procedures followed, the tests performed, the information obtained and the conclusions reached in an examination or investigation performed under this section or ss. 624.316, 624.3161, 624.317, and 624.318. Work papers include planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents, and schedules or commentaries prepared or obtained in the course of such examination or investigation.

2.a. Work papers held by the department or office are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution until the examination report is filed or until the investigation is completed or ceases to be active.

b. Information received from another governmental entity or the National Association of Insurance Commissioners, which is confidential or exempt when held by that entity, for use by the department or office in the performance of its examination or investigation duties pursuant to this section or ss. 624.316, 624.3161, 624.317, and 624.318 is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

c. This exemption applies to work papers and such information held by the department or office before, on, or after the effective date of this exemption.

3. Confidential and exempt work papers and information may be disclosed to:

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

b. The National Association of Insurance Commissioners.

4. After an examination report is filed or an investigation is completed or ceases to be active, portions of work papers may remain confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution if disclosure would:

a. Jeopardize the integrity of another active examination or investigation;

b. Impair the safety or financial soundness of the licensee, affiliated party, or insured;

c. Reveal personal financial, medical, or health information;

d. Reveal the identity of a confidential source;

e. Defame or cause unwarranted damage to the good name or reputation of an individual or jeopardize the safety of an individual;

f. Reveal examination techniques or procedures; or

g. Reveal information that is confidential or exempt under sub-subparagraph 2.b.

(c) Lists of insurers or regulated companies are confidential and exempt from s. 119.07(1) if:

1. The financial solvency, condition, or soundness of such insurers or regulated companies is being monitored by the office;

2. The list is prepared to internally coordinate regulation by the office of the financial solvency, condition, or soundness of the insurers or regulated companies; and

3. The office determines that public inspection of such list could impair the financial solvency, condition, or soundness of such insurers or regulated companies.

(4) After the examination report has been filed pursuant to subsection (1), the department or office may publish the results of any such examination in one or more newspapers published in this state whenever it deems it to be in the public interest.

(5) After the examination report of an insurer has been filed pursuant to subsection (1), an affidavit shall be filed with the office, not more than 30 days after the report has been filed, on a form furnished by the office and signed by the officer of the company in charge of the insurer's business in this state, stating that she or he has read the report and that the recommendations made in the report will be considered within a reasonable time.

690-141

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other

section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit

committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

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

624.610 Reinsurance.—
(1) The purpose of this section is to protect the interests of insureds, claimants, ceding insurers, assuming insurers, and the public. It is the intent of the Legislature to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislature requires that upon the insolvency of a non-United States insurer or reinsurer which provides security to fund its United States obligations in accordance with this section, such security shall be maintained in the United States and claims shall be filed with and valued by the state insurance regulator with regulatory oversight, and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies. The Legislature declares that the matters contained in this section are fundamental to the business of insurance in accordance with 15 U.S.C. ss. 1011-1012.
(2) Credit for reinsurance must be allowed a ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of paragraph (3)(a), paragraph (3)(b), or paragraph (3)(c). Credit must be allowed under paragraph (3)(a) or paragraph (3)(b) only for cessions of those kinds or lines of business that the assuming insurer is licensed, authorized, or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed or authorized to transact insurance or reinsurance.
(3)(a) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is authorized to transact insurance or reinsurance in this state.
(b)1. Credit must be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state. An accredited reinsurer is one that:
a. Files with the office evidence of its submission to this state's jurisdiction;
b. Submits to this state's authority to examine its books and records;

c. Is licensed or authorized to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through, licensed, or authorized to transact insurance or reinsurance in at least one state;
d. Files annually with the office a copy of its annual statement filed with the insurance department of its state of domicile any quarterly statements if required by its state of domicile or such quarterly statements if specifically requested by the office, and a copy of its most recent audited financial statement; and
(I) Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has not been denied by the office within 90 days after its submission; or
(II) Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has been approved by the office.
2. The office may deny or revoke an assuming insurer's accreditation if the assuming insurer does not submit the required documentation pursuant to subparagraph 1., if the assuming insurer fails to meet all of the standards required of an accredited reinsurer, or if the assuming insurer's accreditation would be hazardous to the policyholders of this state. In determining whether to deny or revoke accreditation, the office may consider the qualifications of the assuming insurer with respect to all the following subjects:
a. Its financial stability;
b. The lawfulness and quality of its investments;
c. The competency, character, and integrity of its management;
d. The competency, character, and integrity of persons who own or have a controlling interest in the assuming insurer; and
e. Whether claims under its contracts are promptly and fairly adjusted and are promptly and fairly paid in accordance with the law and the terms of the contracts.
3. Credit must not be allowed a ceding insurer if the assuming insurer's accreditation has been revoked by the office after notice and the opportunity for a hearing.
4. The actual costs and expenses incurred by the office to review a reinsurer's request for accreditation and subsequent reviews must be charged to and collected from the requesting reinsurer. If the reinsurer fails to pay the actual costs and expenses promptly when due, the office may refuse to accredit the reinsurer or may revoke the reinsurer's accreditation.
(c)1. Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in paragraph (5)(b), for the payment of the valid claims of its United States ceding insurers and their assigns and successors in interest. To enable the office to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the office information substantially the same as that required to be reported on the NAIC Annual Statement form by authorized insurers. The assuming insurer shall submit to examination of its books and records by the office and bear the expense of examination.
2.a. Credit for reinsurance must not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:
(I) The insurance regulator of the state in which the trust is domiciled; or
(II) The insurance regulator of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.
b. The form of the trust and any trust amendments must be filed with the insurance regulator of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the insurance regulator.
c. The trust remains in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than

February 28 of each year, the trustee of the trust shall report to the insurance regulator in writing the balance of the trust and list the trust's investments at the preceding year end, and shall certify that the trust will not expire prior to the following December 31.

3. The following requirements apply to the following categories of assuming insurer:

a. The trust fund for a single assuming insurer consists of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20 million. Not less than 50 percent of the funds in the trust covering the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers and trusteed surplus shall consist of assets of a quality substantially similar to that required in part II of chapter 625. Clean, irrevocable, unconditional, and evergreen letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (5)(a), effective no later than December 31 of the year for which the filing is made and in the possession of the trust on or before the filing date of its annual statement, may be used to fund the remainder of the trust and trusteed surplus.

b.(I) In the case of a group including incorporated and individual unincorporated underwriters:

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

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

(C) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which $100 million must be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

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

(III) Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the insurance regulator an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

(d) Credit must be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), paragraph (b), or paragraph (c), but only as to the insurance of risks located in jurisdictions in which the reinsurance is required to be purchased by a particular entity by applicable law or regulation of that jurisdiction.

(e) If the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), paragraph (b), paragraph (c), or paragraph (d), the commissioner may allow credit, but only if the assuming insurer holds surplus in excess of $250 million and has a secure financial strength rating from at least two statistical rating organizations deemed acceptable by the commissioner as having experience and expertise in rating insurers doing business in Florida, including, but not limited to, Standard & Poor's, Moody's Investors Service, Fitch Ratings, A.M. Best Company, and Demotech. In determining whether credit should be allowed, the commissioner shall consider the following:

1. The domiciliary regulatory jurisdiction of the assuming insurer.

2. The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and the financial surveillance of the reinsurer.

3. The substance of financial and operating standards for reinsurers in the domiciliary jurisdiction.
4. The form and substance of financial reports required to be filed by the reinsurers in the domiciliary jurisdiction or other public financial statements filed in accordance with generally accepted accounting principles.
5. The domiciliary regulator's willingness to cooperate with United States regulators in general and the office in particular.
6. The history of performance by reinsurers in the domiciliary jurisdiction.
7. Any documented evidence of substantial problems with the enforcement of valid United States judgments in the domiciliary jurisdiction.
8. Any other matters deemed relevant by the commissioner. The commissioner shall give appropriate consideration to insurer group ratings that may have been issued. The commissioner may, in lieu of granting full credit under this subsection, reduce the amount required to be held in trust under paragraph (c).
(f) If the assuming insurer is not authorized or accredited to transact insurance or reinsurance in this state pursuant to paragraph (a) or paragraph (b), the credit permitted by paragraph (c) or paragraph (d) must not be allowed unless the assuming insurer agrees in the reinsurance agreements:
1.a. That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and
b. To designate the Chief Financial Officer, pursuant to s. 48.151, or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding company.
2. This paragraph is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.
(g) If the assuming insurer does not meet the requirements of paragraph (a) or paragraph (b), the credit permitted by paragraph (c) or paragraph (d) is not allowed unless the assuming insurer agrees in the trust agreements, in substance, to the following conditions:
1. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by paragraph (c), or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the insurance regulator with regulatory oversight over the trust or with an order of a United States court of competent jurisdiction directing the trustee to transfer to the insurance regulator with regulatory oversight all of the assets of the trust fund.
2. The assets must be distributed by and claims must be filed with and valued by the insurance regulator with regulatory oversight in accordance with the laws of the state in which the trust is domiciled which are applicable to the liquidation of domestic insurance companies.
3. If the insurance regulator with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof must be returned by the insurance regulator with regulatory oversight to the trustee for distribution in accordance with the trust agreement.
4. The grantor shall waive any right otherwise available to it under United States law which is inconsistent with this provision.

(4) An asset allowed or a deduction from liability taken for the reinsurance ceded by an insurer to an assuming insurer not meeting the requirements of subsections (2) and (3) is allowed in an amount not exceeding the liabilities carried by the ceding insurer. The deduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer, or, in the case of a trust, held in a qualified United States financial institution, as defined in paragraph (5)(b). This security may be in the form of:
(a) Cash in United States dollars;
(b) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets pursuant to part II of chapter 625;
(c) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (5)(a), effective no later than December 31 of the year for which the filing is made, and in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement; or
(d) Any other form of security acceptable to the office.
(5)(a) For purposes of paragraph (4)(c) regarding letters of credit, a "qualified United States financial institution" means an institution that:
1. Is organized or, in the case of a United States office of a foreign banking organization, is licensed under the laws of the United States or any state thereof;
2. Is regulated, supervised, and examined by United States or state authorities having regulatory authority over banks and trust companies; and
3. Has been determined by either the office or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the office.
(b) For purposes of those provisions of this law which specify institutions that are eligible to act as a fiduciary of a trust, a "qualified United States financial institution" means an institution that is a member of the Federal Reserve System or that has been determined by the office to meet the following criteria:
1. Is organized or, in the case of a United States branch or agency office of a foreign banking organization, is licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and
2. Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.
(6) For the purposes of this section only, the term "ceding insurer" includes any health maintenance organization operating under a certificate of authority issued under part I of chapter 641.
(7) After notice and an opportunity for a hearing, the office may disallow any credit that it finds would be contrary to the proper interests of the policyholders or stockholders of a ceding domestic insurer.
(8) Credit must be allowed to any ceding insurer for reinsurance otherwise complying with this section only when the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer. Such credit must be allowed to the ceding insurer for reinsurance otherwise complying with this section only when the reinsurance agreement provides that payments by the assuming insurer will be made directly to the ceding insurer or its receiver, except when:
(a) The reinsurance contract specifically provides payment to the named insured, assignee, or named beneficiary of the policy issued by the ceding insurer in the event of the insolvency of the ceding insurer; or

(b) The assuming insurer, with the consent of the named insured, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer in substitution for the obligations of the ceding insurer to the named insured.
(9) No person, other than the ceding insurer, has any rights against the reinsurer which are not specifically set forth in the contract of reinsurance or in a specific written, signed agreement between the reinsurer and the person.
(10) An authorized insurer may not knowingly accept as assuming reinsurer any risk covering subject of insurance which is resident, located, or to be performed in this state and which is written directly by any insurer not then authorized to transact such insurance in this state, other than as to surplus lines insurance lawfully written under part VIII of chapter 626.
(11)(a) Any domestic or commercially domiciled insurer ceding directly written risks of loss under this section shall, within 30 days after receipt of a cover note or similar confirmation of coverage, or, without exception, no later than 6 months after the effective date of the reinsurance treaty, file with the office one copy of a summary statement containing the following information about each treaty:
1. The contract period;
2. The nature of the reinsured's business;
3. An indication as to whether the treaty is proportional, nonproportional, coinsurance, modified coinsurance, or indemnity, as applicable;
4. The ceding company's loss retention per risk;
5. The reinsured limits;
6. Any special contract restrictions;
7. A schedule of reinsurers assuming the risks of loss;
8. An indication as to whether payments to the assuming insurer are based on written premiums or earned premiums;
9. Identification of any intermediary or broker used in obtaining the reinsurance and the commission paid to such intermediary or broker if known; and
10. Ceding commissions and allowances.
(b) The summary statement must be signed and attested to by either the chief executive officer or the chief financial officer of the reporting insurer. In addition to the summary statement, the office may require the filing of any supporting information relating to the ceding of such risks as it deems necessary. If the summary statement prepared by the ceding insurer discloses that the net effect of a reinsurance treaty or treaties (or series of treaties with one or more affiliated reinsurers entered into for the purpose of avoiding the following threshold amount) at any time results in an increase of more than 25 percent to the insurer's surplus as to policyholders, then the insurer shall certify in writing to the office that the relevant reinsurance treaty or treaties comply with the accounting requirements contained in any rule adopted by the commission under subsection (14). If such certificate is filed after the summary statement of such reinsurance treaty or treaties, the insurer shall refile the summary statement with the certificate. In any event, the certificate must state that a copy of the certificate was sent to the reinsurer under the reinsurance treaty.
(c) This subsection applies to cessions of directly written risk or loss. This subsection does not apply to contracts of facultative reinsurance or to any ceding insurer that has a surplus as to policyholders which exceeds $100 million as of the immediately preceding December 31. A ceding insurer otherwise subject to this section which had less than $500,000 in direct premiums written in this state during the preceding calendar year and no more than $250,000 in direct premiums written in this state during the preceding calendar quarter, and which had fewer than 1,000 policyholders at the end of the preceding calendar year, is exempt from this subsection.
(d) An authorized insurer not otherwise exempt from the provisions of this subsection shall provide the information required by this subsection with underlying and supporting documentation upon written request of the office.

(e) The office may, upon a showing of good cause, waive the requirements of this subsection.
(12) If the office finds that a reinsurance agreement creates a substantial risk of insolvency to either insurer entering into the reinsurance agreement, the office may by order require a cancellation of the reinsurance agreement.
(13) No credit shall be allowed for reinsurance with regard to which the reinsurance agreement does not create a meaningful transfer of risk of loss to the reinsurer.
(14) The commission may adopt rules implementing the provisions of this section. Rules are authorized to protect the interests of insureds, claimants, ceding insurers, assuming insurers, and the public. These rules shall be in substantial compliance with:
(a) The National Association of Insurance Commissioners model regulations relating to credit for reinsurance;
(b) The National Association of Insurance Commissioners Accounting Practices and Procedures Manual as of March 2002 and subsequent amendments thereto if the methodology remains substantially consistent; and
(c) The National Association of Insurance Commissioners model regulation for Credit for Reinsurance and Life and Health Reinsurance Agreements.

The commission may further adopt rules to provide for transition from existing requirements for the approval of reinsurers to the accreditation of reinsurers pursuant to this section.

(15) Any reinsurer approved pursuant to s. 624.610(3)(a)2., as such provision existed prior to July 1, 2000, which fails to obtain accreditation pursuant to this section prior to December 30, 2003, shall have its approval terminated by operation of law on that date.
(16) This act shall apply to all cessions on or after January 1, 2001, under reinsurance agreements that have an inception, anniversary, or renewal date on or after January 1, 2001.

624.80 Definitions.—As used in this part:
(1) "Insurer" means and includes every person as defined in s. 624.03 as limited to:
(a) Any domestic or commercially domiciled insurer who is doing business as an insurer, or has transacted insurance in this state, and against whom claims arising from that transaction may exist now or in the future.
(b) Any specialty insurer as that term is defined in s. 628.4615.
(c) Any domestic or commercially domiciled fraternal benefit society which is subject to the provisions of chapter 632.
(2) "Unsound condition" means that the office has determined that one or more of the following conditions exist with respect to an insurer:
(a) The insurer's required surplus, capital, or capital stock is impaired to an extent prohibited by law;
(b) The insurer continues to write new business when it has not maintained the required surplus or capital;
(c) The insurer attempts to dissolve or liquidate without first having made provisions, satisfactory to the office, for liabilities arising from insurance policies issued by the insurer; or
(d) The insurer meets one or more of the grounds in s. 631.051 for the appointment of the department as receiver.
(3) "Exceeded its powers" means the following conditions:
(a) The insurer has refused to permit examination by the office of its books, papers, accounts, records, or business practices;
(b) An insurer organized in this state has unlawfully removed from this state books, papers, accounts, or records necessary for an examination of the insurer by the office;

(c) The insurer has failed to promptly comply with the applicable financial reporting statutes and office requests relating thereto;
(d) The insurer has neglected or refused to observe an order of the office to correct a deficiency in its capital or surplus; or
(e) The insurer has unlawfully or in violation of an office order:
1. Totally reinsured its entire outstanding business; or
2. Merged or consolidated substantially its entire property or business with another insurer.
(4) "Consent" means authorized written agreement to supervision by the insurer.
(5) "Commercially domiciled insurer" means and includes any foreign or alien insurer which, during its 3 preceding fiscal years taken together, or during any lesser period of time if not authorized to do business in this state or if it has been licensed to transact its business in this state only for the lesser period of time, has written an average of 25 percent or more direct premiums in this state than it has written in its state of domicile during the same period, or the direct premiums written in this state constitute more than 55 percent of its total direct premiums written everywhere in the United States during its 3 preceding fiscal years taken together, or during any lesser period of time if not authorized to do business in this state or if it has been authorized to transact its business in this state only for the lesser period of time, as reported in its most recent applicable annual or quarterly statements.

624.81 Notice to comply with written requirements of office; noncompliance.—
(1) If the office determines that the conditions set forth in subsection (2) exist, the office shall issue an order placing the insurer in administrative supervision, setting forth the reasons giving rise to the determination, and specifying that the office is applying and effectuating the provisions of this part. An order issued by the office pursuant to this subsection entitles the insurer to request a proceeding under ss. 120.569 and 120.57, and such a request shall stay the action pending such proceeding.
(2) An insurer shall be subject to administrative supervision by the office if upon examination or at any other time the office determines that:
(a) The insurer is in unsound condition;
(b) The insurer's methods or practices render the continuance of its business hazardous to the public or to its insureds; or
(c) The insurer has exceeded its powers granted under its certificate of authority and applicable law.
(3) Within 15 days of receipt of notice of the office's determination to proceed under this part, an insurer shall submit to the office a plan to correct the conditions set forth in the notice. For good cause shown, the office may extend the 15-day time period for submission of the plan. If the office and the insurer agree on a corrective plan, a written agreement shall be entered into to carry out the plan.
(4) If an insurer fails to timely submit a plan, the office may specify the requirements of a plan to address the conditions giving rise to imposition of administrative supervision under this part. In addition, failure of the insurer to timely submit a plan is a violation of the provisions of this code punishable in accordance with s. 624.418.
(5) The plan shall address, but shall not be limited to, each of the activities of the insurer's business which are set forth in s. 624.83.
(6) Any insurer subject to administrative supervision is expected to avail itself of all reasonably available reinsurance. Reasonably available reinsurance shall include unrealized reinsurance, which is defined as reinsurance recoverable on known losses incurred and due under valid reinsurance contracts that have not been identified in the normal course of business and have not been reported in financial statements filed with the Office of

Insurance Regulation. Within 90 days of being placed under administrative supervision, the insurer shall certify to the Director of the Office of Insurance Regulation that the insurer has engaged an independent third party to search for unrealized reinsurance, and that the insurer has made all relevant books and records available to the third party. The compensation to the third party may be a percentage of unrealized reinsurance identified and collected.
(7) If the office and the insurer are unable to agree on the provisions of the plan, the office may require the insurer to take such corrective action as may be reasonably necessary to remove the causes and conditions giving rise to the need for administrative supervision.
(8) The insurer shall have 60 days, or a longer period of time as designated by the office but not to exceed 120 days, after the date of the written agreement or the receipt of the office's plan within which to comply with the requirements of the office. At the conclusion of the initial period of supervision, the office may extend the supervision in increments of 60 days or longer, not to exceed 120 days, if conditions justifying supervision exist. Each extension of supervision shall provide the insurer with a point of entry pursuant to chapter 120.
(9) The initiation or pendency of administrative proceedings arising from actions taken under this section shall not preclude the office from initiating judicial proceedings to place an insurer in conservation, rehabilitation, or liquidation or initiating other delinquency proceedings however designated under the laws of this state.
(10) If it is determined that the conditions giving rise to administrative supervision have been remedied so that the continuance of its business is no longer hazardous to the public or to its insureds, the office shall release the insurer from supervision.
(11) The commission may adopt rules to define standards of hazardous financial condition and corrective action substantially similar to that indicated in the National Association of Insurance Commissioners' 1997 "Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition," which are necessary to implement the provisions of this part.

625.012 "Assets" defined.—In any determination of the financial condition of an insurer, there shall be allowed as "assets" only such assets as are owned by the insurer and which consist of:
(1) Cash or cash equivalents, in the possession of the insurer, or in transit under its control, and including the true balance of any deposit in a solvent bank, savings and loan association, or trust company. Cash equivalents are short-term, highly liquid investments, with original maturities of 3 months or less, which are both readily convertible to known amounts of cash and so near their maturity that they present insignificant risk of changes in value because of changes in interest rates.
(2) Investments, securities, properties, and loans acquired or held in accordance with this code, and in connection therewith the following items:
(a) Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest.
(b) Declared and unpaid dividends on stock and shares, unless such amount has otherwise been allowed as an asset.
(c) Interest due or accrued upon a collateral loan in an amount not to exceed 1 year's interest thereon.
(d) Interest due or accrued on deposits in solvent banks, savings and loan associations, and trust companies, and interest due or accrued on other assets, if such interest is in the judgment of the office a collectible asset.
(e) Interest due or accrued on a current mortgage loan, in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes

thereon over the unpaid principal; but in no event shall interest accrued for a period in excess of 90 days be allowed as an asset.
(f) Rent due or accrued on real property if such rent is not in arrears for more than 3 months, and rent more than 3 months in arrears if the payment of such rent is adequately secured by property held in the name of the tenant and conveyed to the insurer as collateral.
(g) The unaccrued portion of taxes paid prior to the due date on real property.
(3) Premium notes, policy loans, and other policy assets and liens on policies and certificates of life insurance and annuity contracts and accrued interest thereon, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy.
(4) The net amount of uncollected and deferred premiums and annuity considerations in the case of a life insurer.
(5)(a) Premiums in the course of collection, other than for life insurance, not more than 3 months past due, less commissions payable thereon. The foregoing limitation shall not apply to premiums payable directly or indirectly by the United States Government or by any of its instrumentalities. All premiums, excluding commissions payable thereon, due from a controlling or controlled person shall not be allowed as an asset to the extent that:
1. The premiums collected by the controlling or controlled person and not remitted to the insurer are not held in a trust account with a bank or other depository approved by the office. Such funds shall be held as trust funds and may not be commingled with any other funds of the controlling or controlled person. Disbursements from the trust account may be made only to the insurer, the insured, or, for the purpose of returning premiums, an entity who is entitled to returned premiums on behalf of the insured. A written copy of the trust agreement must be filed with and approved by the office prior to its becoming effective. However, the investment income derived from the trust may be allocated as the parties deem proper. A controlling or controlled person shall deposit premiums collected into the trust account within 15 working days after collection;
2. The controlling or controlled person has not provided to the insurer and the insurer has not maintained in its possession an unexpired, clean irrevocable letter of credit, payable to the insurer, issued for a term of not less than 1 year and in conformity with the requirements set forth in this subparagraph, the amount of which equals or exceeds the liability of the controlling or controlled person to the insurer, at all times during the period which the letter of credit is in effect, for premiums collected by the controlling or controlled person. The requirements are that such letter of credit be issued under arrangements satisfactory to the office and that the letter be issued by a banking institution which is a member of the Federal Reserve System and which has a financial standing satisfactory to the office;
3. The controlling or controlled person has not provided to the insurer and the insurer maintained in its possession evidence that the controlling or controlled person has purchased and has currently in effect a financial guaranty bond, payable to the insurer, issued for a term of not less than 1 year and which is in conformity with the requirements set forth in this subparagraph, the amount of which equals or exceeds the liability of the controlling or controlled person to the insurer, at all times during which the financial guaranty bond is in effect, for the premiums collected by the controlling or controlled person. The requirements are that such a financial guaranty bond shall be issued under an arrangement satisfactory to the office and that the financial guaranty bond be issued by an insurer authorized to transact such business in Florida and which has a financial standing satisfactory to the office and which is neither controlled nor controlling in relation to either the insurer or the person for whom the bond is purchased; or
4. A financial evaluation indicates that the controlling or controlled person is unlikely to have the ability to pay such premiums as they become due. The financial evaluation shall be based on a review of the books and records of the controlling or controlled person.

(b) For the purpose of this subsection:
1. "Controlling person" means any person owning, directly or indirectly, 25 percent or more of the voting securities of the insurer.
2. "Controlled person" means any person that is, directly or indirectly, owned or controlled by a controlling person.
3. "Controlling" or "controlled person" means any person that individually or in combination with other such persons owes to the insurer an amount that exceeds 50 percent of the insurer's total premiums in course of collection as stated on the insurer's financial statement.
(c) The office shall disapprove any trust agreement filed pursuant to paragraph (a) which does not assure the safety of the premiums collected.
(6) Installment premiums other than life insurance premiums to the extent of the unearned premium reserve carried on the policy to which such premiums apply.
(7) Notes and like written obligations not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on such basis, to the extent of the unearned premium reserves carried thereon.
(8) The full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and which reinsurance is authorized under s. 624.610.
(9) Amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty.
(10) Deposits or equities recoverable from underwriting associations, syndicates, and reinsurance funds, or from any suspended banking institution, to the extent deemed by the office available for the payment of losses and claims and at values to be determined by it.
(11) Electronic and mechanical machines, including computer-operating software equipment and system software constituting a data processing and accounting system, the cost of which is at least $25,000, which cost shall be amortized in full over a period not to exceed 3 calendar years. The aggregate amount admitted under this subsection shall be limited to 3 percent of the insurer's capital and surplus, adjusted to exclude any electronic data processing equipment and operating software, net deferred tax assets, and net positive goodwill, as reported on the insurer's most recently filed annual statement.
(12) Goodwill arising from acquisitions and mergers occurring after January 1, 2001.
(13) Loans or advances by an insurer to its parent or principal owner if approved by the office.
(14) Current income tax recoverables.
(15)(a) Assessments levied pursuant to s. 631.57(3)(a) and (e) that are paid before policy surcharges are collected and result in a receivable for policy surcharges to be collected in the future. This amount, to the extent it is likely that it will be realized, meets the definition of an admissible asset as specified in the National Association of Insurance Commissioners' Statement of Statutory Accounting Principles No. 4. The asset shall be established and recorded separately from the liability regardless of whether it is based on a retrospective or prospective premium-based assessment. If an insurer is unable to fully recoup the amount of the assessment because of a reduction in writings or withdrawal from the market, the amount recorded as an asset shall be reduced to the amount reasonably expected to be recouped.
(b) Assessments levied as monthly installments pursuant to s. 631.57(3)(e)3. that are paid after policy surcharges are collected so that the recognition of assets is based on actual premium written offset by the obligation to the Florida Insurance Guaranty Association.
(16) Capitalized interest.
(17) Other assets, not inconsistent with the provisions of this section, deemed by the office to be available for the payment of losses and claims, at values to be determined by it.

625.172 Replacing certain assets; reporting certain liabilities.—

(1) The office, upon determining that an insurer's asset has not been evaluated according to applicable law or that it does not qualify as an asset, shall require the insurer to properly reevaluate the asset or replace the asset with an asset suitable to the office.
(2) The office, upon determining that an insurer has failed to report certain liabilities that should have been reported, shall require that the insurer report such liabilities to the office within 90 days.
(3) If it is determined that the proper valuation of an asset or the establishment of certain liabilities would place the insurer in financial impairment or insolvency, the office may, at its discretion, immediately suspend the certificate of authority of an insurer or take other action it deems appropriate to protect the interests of policyholders or the general public.

625.302 Eligible investments.—
(1) Insurers shall invest in or lend their funds on the security of, and shall hold as invested assets, only eligible investments as prescribed in this part of this chapter.
(2) Any particular investment held by an insurer on the effective date of this code, and which was a legal investment at the time it was made, and which the insurer was legally entitled to possess immediately prior to such effective date, shall be deemed to be an eligible investment.
(3) Eligibility of an investment shall be determined as of the date of its making or acquisition, except as stated in subsection (2).
(4) Any investment limitation based upon the amount of the insurer's assets or particular funds shall relate to such assets or funds as shown by the insurer's annual statement as of December 31 next preceding date of acquisition of the investment by the insurer, or as shown by a current financial statement of the insurer.

625.330 Special investments by title insurer.—
(1) In addition to other investments eligible under this part, a title insurer may invest and have invested an amount not exceeding the greater of $300,000 or 50 percent of that part of its surplus as to policyholders which exceeds the minimum surplus required by s. 624.408 in its abstract plant and equipment, in loans secured by mortgages on abstract plants and equipment, and, with the consent of the office, in stocks of abstract companies. If the insurer transacts kinds of insurance in addition to title insurance, for the purposes of this section its paid-in capital stock shall be prorated between title insurance and such other insurances upon the basis of the reserves maintained by the insurer for the various kinds of insurance; but the capital so assigned to title insurance shall in no event be less than $100,000.
(2) Subsection (1) does not apply to a business trust insurer. Such an insurer may invest and have invested not exceeding the greater of $300,000 or 50 percent of its net trust fund in excess of the reserve provided for under s. 625.111 in abstract plants, stock in abstract companies, or corporations controlled by the business trust and created for developing and servicing abstract plants.
(3) Investments authorized by this section shall not be credited against the insurer's required unearned premium or guaranty fund reserve provided for under s. 625.111.

625.332 Prohibited investments and investment underwriting.—
(1) In addition to investments excluded pursuant to other provisions of this code, an insurer shall not directly or indirectly invest in or lend its funds upon the security of:
(a) Issued shares of its own capital stock, except for the purpose of mutualization under s. 628.431, or in connection with a plan approved by the office for purchase of such shares by the insurer's officers, employees, or agents. No such stock shall, however, constitute an asset of the insurer in any determination of its financial condition.

(b) Except with the consent of the office, securities issued by any corporation or enterprise the controlling interest of which is, or will after such acquisition by the insurer be, held directly or indirectly by the insurer or any combination of the insurer and the insurer's directors, officers, parent corporation, subsidiaries, or controlling stockholders. Investments in subsidiaries under s. 625.325 shall not be subject to this provision.
(c) Any note or other evidence of indebtedness of any director, officer, or controlling stockholder of the insurer, except as to policy loans authorized under s. 625.321.
(2) No insurer shall underwrite or participate in the underwriting of an offering of securities or property by any other person.

625.338 Time limit for disposal of ineligible property and securities; effect of failure to dispose.—
(1) Any property or securities lawfully acquired by an insurer which it could not otherwise have invested in or loaned its funds upon at the time of such acquisition shall be disposed of within 3 years from the date of acquisition, unless within such period the security has attained to the standard of eligibility except that any security or property acquired under any agreement of bulk reinsurance, merger, or consolidation may be retained for a longer period if so provided in the plan for such reinsurance, merger, or consolidation as approved by the office under chapter 628. Upon application by the insurer and proof that forced sale of any such property or security would materially injure the interests of the insurer, the office may extend the disposal period for an additional reasonable time.
(2) Any property or securities lawfully acquired and held by an insurer after expiration of the period for disposal thereof or any extension of such period granted by the office shall not be allowed as an asset of the insurer.

69O-137

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

624.4085 Risk-based capital requirements for insurers.—
(1) As used in this section, the term:
(a) "Adjusted risk-based capital report" means a risk-based capital report that has been adjusted by the office in accordance with this section.
(b) "Authorized control level risk-based capital" means the number determined under the risk-based capital formula in the risk-based capital instructions.
(c) "Company action level risk-based capital" means the product of 2.0 and an insurer's authorized control level risk-based capital.
(d) "Corrective order" means an order issued by the office specifying corrective actions that the office has determined are required.
(e) "Domestic insurer" means any insurer domiciled in this state.
(f) "Foreign insurer" means any insurer that is authorized or eligible to do business in this state but that is not domiciled in this state.
(g) "Life and health insurer" means an insurer authorized or eligible under the Florida Insurance Code to underwrite life or health insurance. The term includes a property and casualty insurer that writes accident and health insurance only. Effective January 1, 2015, the term also includes a health maintenance organization that is authorized in this state and one or more other states, jurisdictions, or countries and a prepaid limited health service organization that is authorized in this state and one or more other states, jurisdictions, or countries.
(h) "Mandatory control level risk-based capital" means the product of 0.70 and the authorized control level risk-based capital.
(i) "Negative trend" means, with respect to a life and health insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the risk-based capital instructions.
(j) "Property and casualty insurer" means any insurer licensed under the Florida Insurance Code, but does not include a single-line mortgage guaranty insurer, financial guaranty insurer, or title insurer or a life and health insurer.
(k) "Regulatory action level risk-based capital" means the product of 1.5 and an insurer's authorized control level risk-based capital.
(l) "Revised risk-based capital plan" means the revision of the risk-based capital plan which is prepared by an insurer after the office rejects the original plan.
(m) "Risk-based capital instructions" means the instructions for preparing a risk-based capital report as adopted by the National Association of Insurance Commissioners.
(n) "Risk-based capital level" means an insurer's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital.
(o) "Risk-based capital plan" means a comprehensive financial plan specified in paragraph (4)(b).
(p) "Risk-based capital report" means the report required in subsection (2).
(q) "Total adjusted capital" means the sum of:
1. An insurer's statutory capital and surplus; and
2. Any other item required by the risk-based capital instructions.
(2)(a) Each domestic insurer that is subject to this section shall, on or before March 1 of each year, prepare and file with the National Association of Insurance Commissioners a

report of its risk-based capital levels as of the end of the calendar year just ended, in a form and containing the information required in the risk-based capital instructions. In addition, each domestic insurer shall file a printed copy of its risk-based capital report:

1. With the office on or before March 1 of each year.
2. With the insurance department in any other state in which the insurer is authorized to do business, if that department has notified the insurer of its request in writing, in which case the insurer shall file its risk-based capital report not later than the later of:

a. Fifteen days after the receipt of notice to file its risk-based capital report with that state; or

b. March 1.

(b) The comparison of an insurer's total adjusted capital to any of its risk-based capital levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer, and may not be used as a means to rank insurers generally. Therefore, except as otherwise required under this section, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the risk-based capital levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; however, if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its risk-based capital levels (or any of them) or an inappropriate comparison of any other amount to the insurer's risk-based capital levels is published in any written publication and the insurer is able to demonstrate to the office with substantial proof the falsity or inappropriateness of the statement, the insurer may publish in a written publication an announcement the sole purpose of which is to rebut the materially false statement.

(c) The office shall use the risk-based capital instructions, risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans, and revised risk-based capital plans solely for monitoring the solvency of insurers and assessing the need for corrective action with respect to insurers. The office may not use that information for ratemaking, as evidence in any rate proceeding, or for calculating or deriving any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or an affiliate of such insurer is authorized to write.

(d) A life and health insurer's risk-based capital is determined in accordance with the formula set forth in the risk-based capital instructions. The formula takes into account and may adjust for the covariance between:

1. The risk with respect to the insurer's assets;
2. The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;
3. The interest rate risk with respect to the insurer's business; and
4. Any other business or other relevant risk set out in the risk-based capital instructions,

determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

(e) A property and casualty insurer's risk-based capital is determined in accordance with the formula set forth in the risk-based capital instructions. The formula takes into account and may adjust for the covariance between:

1. The asset risk;
2. The credit risk;

3. The underwriting risk; and
4. Any other business or other relevant risk set out in the risk-based capital instructions,

determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

(f) The Legislature finds that an excess of capital over the amount produced by the risk-based capital requirements and the formulas, schedules, and instructions specified in this section is a desirable goal with respect to the business of insurance. Accordingly, insurers should seek to maintain capital above the risk-based capital levels required by this section. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this section.

(g) If a domestic insurer files a risk-based capital report that the office finds is inaccurate, the office shall adjust the risk-based capital report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice must state the reason for the adjustment. A risk-based capital report that is so adjusted is referred to as the adjusted risk-based capital report. The adjusted risk-based capital report must also be filed by the insurer with the National Association of Insurance Commissioners.

(3)(a) A company action level event includes:

1. The filing of a risk-based capital report by an insurer which indicates that:

a. The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based capital;

b. If a life and health insurer reports using the life and health annual statement instructions, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital, but is less than the product of its authorized control level risk-based capital and 3.0, and has a negative trend;

c. Effective January 1, 2015, if a life and health or property and casualty insurer reports using the health annual statement instructions, the insurer or organization has total adjusted capital that is greater than or equal to its company action level risk-based capital, but is less than the product of its authorized control level risk-based capital and 3.0, and triggers the trend test determined in accordance with the trend test calculation included in the Risk-Based Capital Forecasting and Instructions, Health, updated annually by the NAIC; or

d. If a property and casualty insurer reports using the property and casualty annual statement instructions, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital, but less than the product of its authorized control level risk-based capital and 3.0, and triggers the trend test determined in accordance with the trend test calculation included in the Risk-Based Capital Forecasting and Instructions, Property/Casualty, updated annually by the NAIC;

2. The notification by the office to the insurer of an adjusted risk-based capital report that indicates an event in subparagraph 1., unless the insurer challenges the adjusted risk-based capital report under subsection (7); or

3. If, under subsection (7), an insurer challenges an adjusted risk-based capital report that indicates an event in subparagraph 1., the notification by the office to the insurer that the office has, after a hearing, rejected the insurer's challenge.

(b) If a company action level event occurs, the insurer shall prepare and submit to the office a risk-based capital plan, which must:

1. Identify the conditions that contribute to the company action level event;

2. Contain proposals of corrective actions that the insurer intends to take and that are reasonably expected to result in the elimination of the company action level event;

3. Provide projections of the insurer's financial results in the current year and at least the 4 succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business may include separate projections for each major line of business and, if separate projections are provided, must separately identify each significant income, expense, and benefit component;
4. Identify the key assumptions affecting the insurer's projections and the sensitivity of the projections to the assumptions; and
5. Identify the quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and any use of reinsurance.
(c) The risk-based capital plan must be submitted:
1. Within 45 days after the company action level event; or
2. If the insurer challenges an adjusted risk-based capital report under subsection (7), within 45 days after notification to the insurer that the office has, after a hearing, rejected the insurer's challenge.
(d) Within 60 days after the submission by an insurer of a risk-based capital plan to the office, the office shall notify the insurer whether the risk-based capital plan must be implemented or is, in the judgment of the office, unsatisfactory. If the office determines that the risk-based capital plan is unsatisfactory, the notification to the insurer must set forth the reasons for the determination and may set forth proposed revisions. Upon notification from the office, the insurer shall prepare a revised risk-based capital plan, which may incorporate by reference any revisions proposed by the office, and shall submit the revised risk-based capital plan to the office:
1. Within 45 days after the notification from the office; or
2. If the insurer challenges the notification from the office under subsection (7), within 45 days after a notification to the insurer that the office has, after a hearing, rejected the insurer's challenge.
(e) If the office notifies an insurer that the insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory, the office may, at its discretion and subject to the insurer's right to a hearing under subsection (7), specify in the notification that the notification is a regulatory action level event.
(f) Each domestic insurer that files a risk-based capital plan or a revised risk-based capital plan with the office shall file a copy of the risk-based capital plan or the revised risk-based capital plan with the insurance department in any other state in which the insurer is authorized to do business if:
1. That state has a risk-based capital law that is substantially similar to paragraph (8)(a); and
2. The insurance department of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the risk-based capital plan or the revised risk-based capital plan in that state no later than the later of:
a. Fifteen days after the receipt of notice to file a copy of its risk-based capital plan or revised risk-based capital plan with the state; or
b. The date on which the risk-based capital plan or the revised risk-based capital plan is filed under paragraph (c) or paragraph (d).
(4)(a) A regulatory action level event includes:
1. The filing of a risk-based capital report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level risk-based capital but is less than its regulatory action level risk-based capital;
2. The notification by the office to the insurer of an adjusted risk-based capital report that indicates the event described in subparagraph 1., unless the insurer challenges the adjusted risk-based capital report under subsection (7);

3. If, under subsection (7), the insurer challenges an adjusted risk-based capital report that indicates the event described in subparagraph 1., the notification by the office to the insurer that the office has, after a hearing, rejected the insurer's challenge;
4. The failure of the insurer to file a risk-based capital report by the filing date, unless the insurer provides an explanation for such failure which is satisfactory to the office and cures the failure within 10 days after the filing date;
5. The failure of the insurer to submit a risk-based capital plan to the office within the time period set forth in paragraph (3)(c);
6. Notification by the office to the insurer that:
a. The risk-based capital plan or the revised risk-based capital plan submitted by the insurer is, in the judgment of the office, unsatisfactory; and
b. This notification constitutes a regulatory action level event with respect to the insurer, unless the insurer challenges the determination under subsection (7);
7. If, under subsection (7), the insurer challenges a determination by the office under subparagraph 6., the notification by the office to the insurer that the office has, after a hearing, rejected the challenge;
8. Notification by the office to the insurer that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan, but only if this failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its risk-based capital plan or revised risk-based capital plan and the office has so stated in the notification, unless the insurer challenges the determination under subsection (7); or
9. If, under subsection (7), the insurer challenges a determination by the office under subparagraph 8., the notification by the office to the insurer that the office has, after a hearing, rejected the challenge.
(b) If a regulatory action level event occurs, the office shall:
1. Require the insurer to prepare and submit a risk-based capital plan or, if applicable, a revised risk-based capital plan;
2. Perform an examination pursuant to s. 624.316 or an analysis, as the office considers necessary, of the assets, liabilities, and operations of the insurer, including a review of the risk-based capital plan or the revised risk-based capital plan; and
3. After the examination or analysis, issue a corrective order specifying such corrective actions as the office determines are required.
(c) In determining corrective actions, the office shall consider any factor relevant to the insurer based upon the office's examination or analysis of the assets, liabilities, and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken as provided in the risk-based capital instructions. The risk-based capital plan or the revised risk-based capital plan must be submitted:
1. Within 45 days after the occurrence of the regulatory action level event;
2. If the insurer challenges an adjusted risk-based capital report under subsection (7), within 45 days after the notification to the insurer that the office has, after a hearing, rejected the insurer's challenge; or
3. If the insurer challenges a revised risk-based capital plan under subsection (7), within 45 days after the notification to the insurer that the office has, after a hearing, rejected the insurer's challenge.
(d) The office may retain actuaries, investment experts, and other consultants to review an insurer's risk-based capital plan or revised risk-based capital plan, examine or analyze the assets, liabilities, and operations of an insurer, and formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants must be borne by the affected insurer or by any other party as directed by the office.
(5)(a) An authorized control level event includes:

1. The filing of a risk-based capital report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level risk-based capital but is less than its authorized control level risk-based capital;
2. The notification by the office to the insurer of an adjusted risk-based capital report that indicates the event in subparagraph 1., unless the insurer challenges the adjusted risk-based capital report under subsection (7);
3. If, under subsection (7), the insurer challenges an adjusted risk-based capital report that indicates the event in subparagraph 1., notification by the office to the insurer that the office has, after a hearing, rejected the insurer's challenge;
4. The failure of the insurer to respond, in a manner satisfactory to the office, to a corrective order, unless the insurer challenges the corrective order under subsection (7); or
5. If the insurer challenges a corrective order under subsection (7) and the office has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the office, to the corrective order after rejection or modification by the office.
(b) If an authorized control level event occurs, the office shall:
1. Take any action required under subsection (4) regarding the insurer with respect to which a regulatory action level event has occurred; or
2. If the office considers it to be in the best interests of the policyholders and creditors of the insurer and of the public, take any action as necessary to cause the insurer to be placed under regulatory control under chapter 631. An authorized control level event is sufficient ground for the department to be appointed as receiver as provided in chapter 631.
(6)(a) A mandatory control level event includes:
1. The filing of a risk-based capital report that indicates that the insurer's total adjusted capital is less than its mandatory control level risk-based capital;
2. Notification by the office to the insurer of an adjusted risk-based capital report that indicates the event in subparagraph 1., unless the insurer challenges the adjusted risk-based capital report under subsection (7); or
3. If, under subsection (7), the insurer challenges an adjusted risk-based capital report that indicates the event in subparagraph 1., notification by the office to the insurer that the office has, after a hearing, rejected the insurer's challenge.
(b) If a mandatory control level event occurs:
1. With respect to a life and health insurer, the office shall, after due consideration of s. 624.408, and effective January 1, 2015, ss. 636.045 and 641.225, take any action necessary to place the insurer under regulatory control, including any remedy available under chapter 631. A mandatory control level event is sufficient ground for the department to be appointed as receiver as provided in chapter 631. The office may forego taking action for up to 90 days after the mandatory control level event if the office finds there is a reasonable expectation that the event may be eliminated within the 90-day period.
2. With respect to a property and casualty insurer, the office shall, after due consideration of s. 624.408, take any action necessary to place the insurer under regulatory control, including any remedy available under chapter 631, or, in the case of an insurer that is not writing new business, may allow the insurer to continue to operate under the supervision of the office. In either case, the mandatory control level event is sufficient ground for the department to be appointed as receiver as provided in chapter 631. The office may forego taking action for up to 90 days after the mandatory control level event if the office finds there is a reasonable expectation that the event may be eliminated within the 90-day period.
(7)(a) An insurer has a right to a hearing before the office upon:
1. Notification to an insurer by the office of an adjusted risk-based capital report;
2. Notification to an insurer by the office that the insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory, and that the notification constitutes a regulatory action level event with respect to such insurer;

3. Notification to any insurer by the office that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its risk-based capital plan or its revised risk-based capital plan; or
4. Notification to an insurer by the office of a corrective order with respect to the insurer.
(b) At such hearing the insurer may challenge any determination or action by the office. The insurer shall notify the office of its request for a hearing within 5 days after receipt of the notification by the office under this subsection. Upon receipt of the request for a hearing, the office shall set a date for the hearing, which date must be no fewer than 10 nor more than 30 days after the date the office receives the insurer's request. The hearing must be conducted as provided in s. 624.324, with the right to appellate review under s. 120.68.
(8)(a) Any foreign insurer shall, upon the written request of the office, submit to the office a risk-based capital report, as of the end of the calendar year just ended, no later than the later of:
1. The date a risk-based capital report is required to be filed by a domestic insurer under this section; or
2. Fifteen days after the request is received by the foreign insurer.
(b) Any foreign insurer shall, upon the written request of the office, promptly submit to the office a copy of any risk-based capital plan that is filed with the insurance department of another state.
(c) The office may require a foreign insurer to file a risk-based capital plan if:
1. A company action level event, regulatory action level event, or authorized control level event occurs with respect to any foreign insurer as determined under the risk-based capital law of the state of domicile of the insurer, or, if there is no risk-based capital law in that state, under this section.
2. The insurance department of the state of domicile of the foreign insurer fails to require the foreign insurer to file a risk-based capital plan in the manner specified under the risk-based capital law of that state, or, if there is no risk-based capital law in that state, under subsection (3).

The failure of the foreign insurer to file a risk-based capital plan with the office when required under this paragraph is a ground for the office to take any action under s. 624.418 which it determines is necessary.

(d) If a mandatory control level event occurs with respect to any foreign insurer and a domiciliary receiver has not been appointed with respect to the foreign insurer under the rehabilitation and liquidation law of the state of domicile of the foreign insurer, the office may apply to the Circuit Court of Leon County and such event constitutes grounds for the department to be appointed as receiver as provided in chapter 631 with respect to the liquidation of property of foreign insurers found in this state. The occurrence of a mandatory control level event is a ground for such application.
(9) There shall be no liability on the part of, and no cause of action shall arise against, the commission, department, or office, or their employees or agents, for any action taken by them in the performance of their powers and duties under this section.
(10) The office shall transmit any notice that may result in regulatory action by registered mail, certified mail, or any other method of transmission. Notice is effective when the insurer receives it.
(11) This section is supplemental to the other laws of this state and does not preclude or limit any power or duty of the department or office under those laws or under the rules adopted under those laws.
(12) This section does not apply to a domestic property and casualty insurer that meets all of the following conditions:
(a) Writes direct business only in this state;

(b) Writes direct annual premiums of $2 million or less; and
(c) Assumes no reinsurance in excess of 5 percent of direct premiums written.
(13) The commission may adopt rules to administer this section, including, but not limited to, those regarding risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans, corrective orders and procedures to be followed in the event of a triggering of a company action level event, a regulatory action level event, an authorized control level event, or a mandatory control level event.

624.4243 Reporting of premium growth.—
(1) Each insurer that has been authorized to transact property and casualty insurance in this state for a continuous period of less than 3 years shall monthly calculate its premium growth as follows:
(a) For the 12-month period ending on the last day of the previous month, obtain the amount of the insurer's direct and assumed written premiums for the United States and its territories.
(b) For the 12-month period immediately preceding the 12-month period specified in paragraph (a), obtain the amount of the insurer's direct and assumed written premiums for the United States and its territories.
(c) Subtract the amount of premiums calculated under paragraph (b) from the amount of premiums calculated under paragraph (a).
(d) Divide the amount of premiums determined under paragraph (c) by the amount of premiums determined under paragraph (b).
(2) Until an insurer has held a certificate of authority in this state for 24 months, the insurer shall, instead of making the calculations required under subsection (1), report to the office no later than the last day of each month the insurer's direct and assumed written premiums from the United States and its territories for the previous month.
(3) If the amount of the premium growth calculated by an insurer under this section exceeds 33 percent, the insurer shall, within 30 days after the end of the 12-month period ending on the last day of the previous month, file with the office a statement of the premium growth calculations under this section. The commission shall adopt rules specifying the form for the report. In response to a report under this section, the office may require the insurer to submit an explanation of the insurer's pattern of premium growth.
(4) For the purposes of this section, direct and assumed written premiums shall be calculated in the same manner as for the preparation of the insurer's annual statement under s. 624.424.

624.424 Annual statement and other information.—

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or

reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office. (10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.

624.307 General powers; duties.—

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

624.324 Hearings.—The department, commission, and office may each hold hearings for any purpose within the scope of this code deemed to be necessary.

624.610 Reinsurance.—

(11)(a) Any domestic or commercially domiciled insurer ceding directly written risks of loss under this section shall, within 30 days after receipt of a cover note or similar confirmation of coverage, or, without exception, no later than 6 months after the effective date of the reinsurance treaty, file with the office one copy of a summary statement containing the following information about each treaty:

1. The contract period;
2. The nature of the reinsured's business;
3. An indication as to whether the treaty is proportional, nonproportional, coinsurance, modified coinsurance, or indemnity, as applicable;
4. The ceding company's loss retention per risk;
5. The reinsured limits;
6. Any special contract restrictions;
7. A schedule of reinsurers assuming the risks of loss;
8. An indication as to whether payments to the assuming insurer are based on written premiums or earned premiums;
9. Identification of any intermediary or broker used in obtaining the reinsurance and the commission paid to such intermediary or broker if known; and
10. Ceding commissions and allowances.

(b) The summary statement must be signed and attested to by either the chief executive officer or the chief financial officer of the reporting insurer. In addition to the summary statement, the office may require the filing of any supporting information relating to the ceding of such risks as it deems necessary. If the summary statement prepared by the ceding insurer discloses that the net effect of a reinsurance treaty or treaties (or series of treaties with one or more affiliated reinsurers entered into for the purpose of avoiding the following threshold amount) at any time results in an increase of more than 25 percent to the insurer's surplus as to policyholders, then the insurer shall certify in writing to the office that the relevant reinsurance treaty or treaties comply with the accounting requirements contained in any rule adopted by the commission under subsection (14). If such certificate is filed after the summary statement of such reinsurance treaty or treaties, the insurer shall refile the summary statement with the certificate. In any event, the certificate must state that a copy of the certificate was sent to the reinsurer under the reinsurance treaty.

(c) This subsection applies to cessions of directly written risk or loss. This subsection does not apply to contracts of facultative reinsurance or to any ceding insurer that has a surplus as to policyholders which exceeds $100 million as of the immediately preceding December 31. A ceding insurer otherwise subject to this section which had less than $500,000 in direct premiums written in this state during the preceding calendar year and no more than $250,000 in direct premiums written in this state during the preceding calendar quarter, and which had fewer than 1,000 policyholders at the end of the preceding calendar year, is exempt from this subsection.

(d) An authorized insurer not otherwise exempt from the provisions of this subsection shall provide the information required by this subsection with underlying and supporting documentation upon written request of the office.

(e) The office may, upon a showing of good cause, waive the requirements of this subsection.

69O-198

634.402 Powers of department, commission, and office; rules.—The office shall administer this part, and the commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part related to service warranty associations and service warranties. The department shall administer this part and may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this part related to sales representatives. Such rules by the commission or department may identify specific methods of competition or acts or practices that are prohibited by s. 634.436, but shall not enlarge upon or extend the provisions of that section.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers

subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified

public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

634.405 Required deposit or bond.—
(1) To assure the faithful performance of its obligations to its members or subscribers in the event of insolvency, each service warranty association shall, before the issuance of its license by the office and during such time as the association may have premiums in force in this state, deposit and maintain with the department securities of the type eligible for deposit by insurers under s. 625.52. Whenever the market value of the securities deposited with the department is less than 95 percent of the amount required, the association shall deposit additional securities or otherwise increase the deposit to the amount required. Such securities shall have at all times a market value as follows:
(a) Warrantors.—
1. Any warrantor which:
a. Was licensed under this part before October 1, 1983;
b. Was transacting service warranty business in this state before June 14, 1978;
c. Has continuously transacted service warranty business in this state since June 14, 1978; and
d. Has not during any year since June 14, 1978, written more than $100,000 of gross written premiums,

shall place and maintain in trust with the department an amount equal to 50 percent of the gross written premiums in force.

2. A warrantor which has $300,000 or less of gross written premiums in this state and to which the provisions of subparagraph 1. do not apply shall place and maintain in trust with the department an amount not less than $50,000. A new warrantor, before the issuance of its license and before receiving any premiums, shall place and maintain in trust with the department the amount of $50,000.
3. A warrantor which has more than $300,000 but less than $750,000 of gross written premiums in this state shall place and maintain in trust with the department an amount not less than $75,000.
4. A warrantor which has $750,000 or more of gross written premiums in this state shall place and maintain in trust with the department an amount equal to $100,000.
5. All warrantors, upon receipt of written notice from the office, shall have 30 calendar days in which to make additional deposits.
(b) Warranty sellers.—A warranty seller shall, before the issuance of its license, place in trust with the department an amount not less than $100,000.

(2) In lieu of any deposit of securities required under subsection (1) and subject to the approval of the office, the service warranty association may file with the office a surety bond issued by an authorized surety insurer. The bond shall be for the same purpose as the deposit in lieu of which it is filed. The office may not approve any bond under the terms of which the protection afforded against insolvency is not equivalent to the protection afforded by those securities provided for in subsection (1). When a bond is deposited in lieu of the required securities, no warranties may be written which provide coverage for a time period beyond the duration of such bond. The bond shall guarantee that the service warranty association will faithfully and truly perform all the conditions of any service warranty contract. No such bond may be canceled or subject to cancellation unless at least 60 days' advance notice thereof, in writing, is filed with the office. In the event that notice of termination of the bond is filed with the office, the service warranty association insured thereunder shall, within 30 days of the filing of notice of termination, provide the office with a replacement bond meeting the requirements of this part or deposit additional securities as required under subsection (1). The cancellation of a bond will not relieve the obligation of the issuer of the bond for claims arising out of contracts issued before cancellation of the bond unless a replacement bond or securities are filed. In no event may the liability of the issuer under the bond exceed the face amount of the bond. If within 30 days of filing the notice of termination no replacement bond or additional security is provided, the office shall suspend the license of the association until the deposit requirements are satisfied.
(3) Securities and bonds posted by an association pursuant to this section are for the benefit of, and subject to action thereon in the event of insolvency or impairment of any association or insurer by, any person or persons sustaining an actionable injury due to the failure of the association to faithfully perform its obligations to its warranty holders.
(4) The state is responsible for the safekeeping of all securities deposited with the department under this part. Such securities are not, on account of being in this state, subject to taxation, but shall be held exclusively and solely to guarantee the faithful performance by the association of its obligations to its members or subscribers.
(5) The depositing association shall, during its solvency, have the right to exchange or substitute other securities of like quality and value for securities on deposit, to receive the interest and other income accruing to such securities, and to inspect the deposit at all reasonable times.
(6) Such deposit or bond shall be maintained unimpaired as long as the association continues in business in this state. Whenever the association ceases to do business in this state and furnishes the office proof satisfactory to the office that it has discharged or otherwise adequately provided for all its obligations to its members or subscribers in this state, the office and department shall release the deposited securities to the parties entitled thereto, on presentation of the receipts of the department for such securities, or shall release any bond filed with it in lieu of such deposit.
(7) Any business, or its affiliate, whose primary source of income is the sale of goods to the final consumer and derives more than 50 percent of its revenue through such sales and maintains a net worth of $100 million, as evidenced by either filing a form 10-K or other similar statement with the Securities and Exchange Commission or which has an annual financial statement that is audited and certified by an independent public accounting firm, shall be presumed to have complied with this subsection if such forms or statement are filed with the office.

634.407 Application for and issuance of license.—
(1) An application for license as a service warranty association shall be made to, and filed with, the office on printed forms as prescribed by the commission and furnished by the office.

(2) In addition to information relative to its qualifications as required under s. 634.404, the commission may require that the application show:
(a) The location of the applicant's home office.
(b) The name and residence address of each director, officer, and 10-percent or greater stockholder of the applicant.
(c) Such other pertinent information as may be required by the commission.
(3) The commission may require that the application, when filed, be accompanied by:
(a) A copy of the applicant's articles of incorporation, certified by the public official having custody of the original, and a copy of the applicant's bylaws, certified by the applicant's secretary.
(b) A copy of the most recent financial statement of the applicant, verified under oath of at least two of its principal officers.
(c) A license fee in the amount of $200, as required under s. 634.403.
(4) Upon completion of the application for license, the office shall examine the application and make such further investigation of the applicant as it deems advisable. If it finds that the applicant is qualified therefor, the office shall issue to the applicant a license as a service warranty association. If the office does not find the applicant to be qualified, it shall refuse to issue the license and shall give the applicant written notice of such refusal, setting forth the grounds therefor.

634.408 License continuance.—A license issued under this part shall continue in force as long as the service warranty association is entitled thereto under this part and until suspended, revoked, or terminated at the request of the service warranty association. However, to continue the license, annually in conjunction with the March 1 filing of the annual statement, each service warranty association shall file a $200 license fee.

634.4085 Acquisition.—Except for manufacturers as defined in this part, every service warranty association shall be subject to the provisions of s. 628.4615.

634.415 Tax on premiums; annual statement; reports.—
(1) In addition to the license fees provided in this part for service warranty associations and license taxes as provided in the insurance code as to insurers, each such association and insurer shall, annually on or before March 1, file with the office its annual statement, in the form prescribed by the commission, showing all premiums or assessments received by it in connection with the issuance of service warranties in this state during the preceding calendar year and using accounting principles which will enable the office to ascertain whether the financial requirements set forth in s. 634.406 have been satisfied.
(2) The gross amount of premiums and assessments is subject to the sales tax imposed by s. 212.0506.
(3) The office may levy a fine of up to $100 a day for each day an association neglects to file the annual statement in the form and within the time provided by this part. The amount of the fine shall be established by rules adopted by the commission. The office shall deposit all sums collected by it under this section to the credit of the Insurance Regulatory Trust Fund.
(4) The office may suspend or revoke the license of a service warranty association failing to file its annual statement when due.
(5) The commission may by rule require each service warranty association to submit to the office, as the commission may designate, all or part of the information contained in the financial statements and reports required by this section in a computer-readable form compatible with the electronic data processing system specified by the office.

690-196

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

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

627.8405 Prohibited acts; financing companies.—No premium finance company shall, in a premium finance agreement or other agreement, finance the cost of or otherwise provide for the collection or remittance of dues, assessments, fees, or other periodic payments of money for the cost of:
(1) A membership in an automobile club. The term "automobile club" means a legal entity which, in consideration of dues, assessments, or periodic payments of money, promises its members or subscribers to assist them in matters relating to the ownership, operation, use, or maintenance of a motor vehicle; however, this definition of "automobile club" does not include persons, associations, or corporations which are organized and operated solely for the purpose of conducting, sponsoring, or sanctioning motor vehicle races, exhibitions, or contests upon racetracks, or upon racecourses established and marked as such for the duration of such particular events. The words "motor vehicle" used herein have the same meaning as defined in chapter 320.
(2) An accidental death and dismemberment policy sold in combination with a personal injury protection and property damage only policy.
(3) Any product not regulated under the provisions of this insurance code.
This section also applies to premium financing by any insurance agent or insurance company under part XVI. The commission shall adopt rules to assure disclosure, at the time of sale, of coverages financed with personal injury protection and shall prescribe the form of such disclosure.

624.321 Witnesses and evidence.—
(1) As to any examination, investigation, or hearing being conducted under this code, a person designated by the department or office, respectively:
(a) May administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence;

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial

statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain:

1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements

of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.

(f) Number of new policies written.

(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:

1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).

2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.

3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.80 Definitions.—As used in this part:

(1) "Insurer" means and includes every person as defined in s. 624.03 as limited to:

(a) Any domestic or commercially domiciled insurer who is doing business as an insurer, or has transacted insurance in this state, and against whom claims arising from that transaction may exist now or in the future.
(b) Any specialty insurer as that term is defined in s. 628.4615.
(c) Any domestic or commercially domiciled fraternal benefit society which is subject to the provisions of chapter 632.
(2) "Unsound condition" means that the office has determined that one or more of the following conditions exist with respect to an insurer:
(a) The insurer's required surplus, capital, or capital stock is impaired to an extent prohibited by law;
(b) The insurer continues to write new business when it has not maintained the required surplus or capital;
(c) The insurer attempts to dissolve or liquidate without first having made provisions, satisfactory to the office, for liabilities arising from insurance policies issued by the insurer; or
(d) The insurer meets one or more of the grounds in s. 631.051 for the appointment of the department as receiver.
(3) "Exceeded its powers" means the following conditions:
(a) The insurer has refused to permit examination by the office of its books, papers, accounts, records, or business practices;
(b) An insurer organized in this state has unlawfully removed from this state books, papers, accounts, or records necessary for an examination of the insurer by the office;
(c) The insurer has failed to promptly comply with the applicable financial reporting statutes and office requests relating thereto;
(d) The insurer has neglected or refused to observe an order of the office to correct a deficiency in its capital or surplus; or
(e) The insurer has unlawfully or in violation of an office order:
1. Totally reinsured its entire outstanding business; or
2. Merged or consolidated substantially its entire property or business with another insurer.
(4) "Consent" means authorized written agreement to supervision by the insurer.
(5) "Commercially domiciled insurer" means and includes any foreign or alien insurer which, during its 3 preceding fiscal years taken together, or during any lesser period of time if not authorized to do business in this state or if it has been licensed to transact its business in this state only for the lesser period of time, has written an average of 25 percent or more direct premiums in this state than it has written in its state of domicile during the same period, or the direct premiums written in this state constitute more than 55 percent of its total direct premiums written everywhere in the United States during its 3 preceding fiscal years taken together, or during any lesser period of time if not authorized to do business in this state or if it has been authorized to transact its business in this state only for the lesser period of time, as reported in its most recent applicable annual or quarterly statements.

624.81 Notice to comply with written requirements of office; noncompliance.—
(1) If the office determines that the conditions set forth in subsection (2) exist, the office shall issue an order placing the insurer in administrative supervision, setting forth the reasons giving rise to the determination, and specifying that the office is applying and effectuating the provisions of this part. An order issued by the office pursuant to this subsection entitles the insurer to request a proceeding under ss. 120.569 and 120.57, and such a request shall stay the action pending such proceeding.

(2) An insurer shall be subject to administrative supervision by the office if upon examination or at any other time the office determines that:
(a) The insurer is in unsound condition;
(b) The insurer's methods or practices render the continuance of its business hazardous to the public or to its insureds; or
(c) The insurer has exceeded its powers granted under its certificate of authority and applicable law.
(3) Within 15 days of receipt of notice of the office's determination to proceed under this part, an insurer shall submit to the office a plan to correct the conditions set forth in the notice. For good cause shown, the office may extend the 15-day time period for submission of the plan. If the office and the insurer agree on a corrective plan, a written agreement shall be entered into to carry out the plan.
(4) If an insurer fails to timely submit a plan, the office may specify the requirements of a plan to address the conditions giving rise to imposition of administrative supervision under this part. In addition, failure of the insurer to timely submit a plan is a violation of the provisions of this code punishable in accordance with s. 624.418.
(5) The plan shall address, but shall not be limited to, each of the activities of the insurer's business which are set forth in s. 624.83.
(6) Any insurer subject to administrative supervision is expected to avail itself of all reasonably available reinsurance. Reasonably available reinsurance shall include unrealized reinsurance, which is defined as reinsurance recoverable on known losses incurred and due under valid reinsurance contracts that have not been identified in the normal course of business and have not been reported in financial statements filed with the Office of Insurance Regulation. Within 90 days of being placed under administrative supervision, the insurer shall certify to the Director of the Office of Insurance Regulation that the insurer has engaged an independent third party to search for unrealized reinsurance, and that the insurer has made all relevant books and records available to the third party. The compensation to the third party may be a percentage of unrealized reinsurance identified and collected.
(7) If the office and the insurer are unable to agree on the provisions of the plan, the office may require the insurer to take such corrective action as may be reasonably necessary to remove the causes and conditions giving rise to the need for administrative supervision.
(8) The insurer shall have 60 days, or a longer period of time as designated by the office but not to exceed 120 days, after the date of the written agreement or the receipt of the office's plan within which to comply with the requirements of the office. At the conclusion of the initial period of supervision, the office may extend the supervision in increments of 60 days or longer, not to exceed 120 days, if conditions justifying supervision exist. Each extension of supervision shall provide the insurer with a point of entry pursuant to chapter 120.
(9) The initiation or pendency of administrative proceedings arising from actions taken under this section shall not preclude the office from initiating judicial proceedings to place an insurer in conservation, rehabilitation, or liquidation or initiating other delinquency proceedings however designated under the laws of this state.
(10) If it is determined that the conditions giving rise to administrative supervision have been remedied so that the continuance of its business is no longer hazardous to the public or to its insureds, the office shall release the insurer from supervision.
(11) The commission may adopt rules to define standards of hazardous financial condition and corrective action substantially similar to that indicated in the National Association of Insurance Commissioners' 1997 "Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition," which are necessary to implement the provisions of this part.

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—
(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:
(a) Misrepresentations and false advertising of insurance policies.—Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, comparison, or property and casualty certificate of insurance altered after being issued, which:
1. Misrepresents the benefits, advantages, conditions, or terms of any insurance policy.
2. Misrepresents the dividends or share of the surplus to be received on any insurance policy.
3. Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy.
4. Is misleading, or is a misrepresentation, as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates.
5. Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof.
6. Is a misrepresentation for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.
7. Is a misrepresentation for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy.
8. Misrepresents any insurance policy as being shares of stock or misrepresents ownership interest in the company.
9. Uses any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the insurance sales activities of any person or stands behind any person's credit or that any person, the state, or the Federal Government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person.

627.734 Proof of security; security requirements; penalties.—
(1) The provisions of chapter 324 which pertain to the method of giving and maintaining proof of financial responsibility and which govern and define a motor vehicle liability policy shall apply to filing and maintaining proof of security required by ss. 627.730-627.7405.
(2) Any person who:
(a) Gives information required in a report or otherwise as provided for in ss. 627.730-627.7405, knowing or having reason to believe that such information is false;
(b) Forges or, without authority, signs any evidence of proof of security; or
(c) Files, or offers for filing, any such evidence of proof, knowing or having reason to believe that it is forged or signed without authority,
is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

627.828 License required.—
(1) Except as provided in ss. 627.901 and 627.902, no person shall engage in the business of a premium finance company unless licensed by the office. Every premium finance company licensed under the provisions of this part shall maintain at all times a net worth of $35,000. However, in lieu of having a net worth of $35,000, a premium finance company that has a net worth of $10,000 may file a surety bond with the office or other acceptable collateral with the department as approved by the office or department in the amount of $35,000, which bond or collateral must be maintained.
(2) The application for a license shall be in writing and in the form prescribed by the commission. Every applicant shall provide evidence of a net worth of $35,000 attested by two officers of the company, or a $35,000 surety bond and evidence of a net worth of

$10,000 attested by two officers of the company. Assets to be used in computing the required net worth shall be determined by rules adopted by the commission.
(3)(a) Each premium finance company authorized under the provisions of this part shall maintain at all times an errors and omissions insurance policy of no less than $500,000 covering the acts of its officers, employees, and agents. The policy may contain reasonable deductibles not to exceed 2 percent of the policy limits.
(b)1. A premium finance company with an unencumbered net worth of at least $15 million may self-insure the errors and omissions coverage if it meets the requirements of this paragraph.
2. To qualify as a self-insurer the premium finance company must:
a. Have and maintain an unencumbered net worth of $15 million, which shall be determined based on assets permissible for insurers pursuant to ss. 625.012 and 625.031;
b. Annually demonstrate as part of its annual report, to the satisfaction of the department, that the net-worth requirement is being met; and
c. Obtain, as a part of its annual application for licensure as a premium finance company, a certificate of self-insurance from the office to be renewed annually.
3. If the office finds that the premium finance company:
a. Is not maintaining at all times an unencumbered net worth of at least $15 million; or
b. Is not, in good faith, covering the errors and omissions of its officers, employees and agents,

the office shall, in addition to other penalties under this code, revoke or suspend the certificate of self-insurance, and the premium finance company shall be subject to the requirements of paragraph (a).

(c) The commission may adopt rules necessary to administer this subsection, including rules prescribing the necessary forms.
(4) A single license shall entitle the holder to operate more than one office.
(5) At the time of filing an application for a license, the applicant shall pay to the office the license fee and, upon original application or upon application subsequent to denial of application, or revocation, suspension or surrender of a license, an investigation fee.
(6) Such license shall state the name and address of the licensee, and a copy shall be kept conspicuously posted in each office of the licensee and shall not be transferable or assignable.
(7) Prior to moving an existing office to another location, a licensee shall notify the office in writing of its intention to do so.

627.829 Approval, disapproval of application; license renewal.—
(1) The office shall issue the license, unless it finds that the management of the premium finance company filing the application is so lacking in managerial experience as to make the proposed operation hazardous to the insurance-buying public or unless it has good reason to believe the management of the premium finance company is affiliated directly or indirectly through ownership, control, or in other business relations with any person whose business operations are or have been marked as detrimental to the public, policyholders, stockholders, investors, or creditors by manipulation of assets or of accounts or by bad faith.
(2) If the office refuses to issue a license, it shall notify the applicant of the denial and return to the applicant the sum paid as a license fee, but shall retain the investigation fee to cover the costs of investigating the applicant.
(3) Each license shall remain in force until September 30 of the year for which issued, unless earlier surrendered, suspended, or revoked, and may be renewed for the ensuing license year upon the filing of an application therefor. If an application for renewal is filed

with the office before October 1 of any year, the license sought to be renewed shall be continued in force either until the issuance by the office of the renewal license applied for or until 5 days after the office refuses to renew the license.

627.832 Grounds for refusal, suspension, or revocation of license.—
(1) The office may deny, suspend, revoke, or refuse to renew any license, if it finds:
(a) That the licensee has failed to pay the annual license fee or any sum of money lawfully demanded under authority of any other section of this part or has failed to comply with any order of the office.
(b) That the licensee has violated any provision of this part or any rule of the commission.
(c) That any fact or condition exists which, if it had existed at the time of the original application, clearly would have warranted a refusal to issue the license.
(d) Material misstatement, misrepresentation, or fraud in obtaining the license or permit, or in attempting to obtain the license or permit.
(e) That the license or permit is being willfully used, or is to be used, to circumvent any of the requirements or prohibitions of this code.
(f) Willful misrepresentation of any premium finance contract or willful deception with regard to any such contract, accomplished either in person or by any form of dissemination of information.
(g) A demonstrated lack of fitness or trustworthiness.
(h) Fraudulent or dishonest practices in the conduct of business.
(i) Misappropriation, conversion, or unlawful withholding of moneys belonging to insurers, insureds, or beneficiaries or to others and received in the conduct of business.
(j) That the licensee has been found guilty of, or has pleaded guilty to, a felony in this state or any other state.
(2) A licensee may surrender a license by delivering to the office written notice that she or he thereby surrenders such license, but such surrender shall not affect such licensee's civil or criminal liability for acts committed prior to such surrender.
(3) No revocation, suspension, or surrender of a license shall impair or affect the obligation of any insured under any lawful premium finance agreement previously acquired or held by the licensee.
(4) Every license issued hereunder shall remain in force and effect until it has been surrendered, revoked, or suspended or expires in accordance with the provisions of this part; but the office may reinstate a suspended license or issue a new license to a licensee whose license has been revoked, if no fact or condition then exists which clearly would have warranted office refusal originally to issue such license under this part.

627.834 Examinations.—
(1) The office may conduct examinations and investigations of premium finance companies under the provisions of ss. 624.307 and 626.601.
(2) As often as it deems necessary and not less frequently than each 3 years, the office shall examine each licensed premium finance company. The examination shall be for the purpose of ascertaining compliance by the person examined with the applicable provisions of this code

627.836 Licensee's books and records; reports.—
(1) The licensee shall keep and use in her or his business such books, accounts, and records as will enable the office to determine whether the licensee is complying with the provisions of this part and with the rules pertaining thereto. Every licensee shall preserve such books, accounts, and records, including cards used in a card system, if any, for at least

3 years after making the final entry in respect to any premium finance agreement recorded therein; however, the preservation of photographic reproductions thereof or records in photographic form shall constitute compliance with this requirement.
(2) Each licensee shall annually, on or before March 1, file a report with the office giving such information as the office may require. The report shall be made under oath and in the form prescribed by the commission and shall be accompanied by the annual report filing fee specified in s. 627.849. The office may make and publish annually an analysis and recapitulation of such reports. In addition, the office may require such additional regular or special reports as it deems necessary. The commission may by rule require all or part of the statements or filings required under this section to be submitted by electronic means in a computer-readable form compatible with the electronic data format specified by the commission.

627.838 Filing and approval of forms; service charges.—
(1) No premium finance agreement form or related form shall be used in this state by a premium finance company unless it has been filed with and approved by the office. Every filing shall be made within 30 days of issuance or use.
(2) Each premium finance company shall file with the office the service charge and interest rate plan, including all modifications thereto, for informational purposes only. Every filing shall be made within 30 days of its effective date.

627.840 Limitation on service and other charges.—
(1) A premium finance company shall not charge, contract for, receive, or collect a service charge other than as permitted by this part.
(2) A premium finance company may, in a premium finance agreement, contract for, charge, receive, and collect a service charge for financing the premiums under the agreement computed as provided in subsection (3).
(3)(a) The service charge provided for in this section shall be computed on the balance of the premiums due, after subtracting the down payment made by the insured in accordance with the premium finance agreement, from the effective date of the insurance coverage for which the premiums are being advanced to and including the date when the final payment of the premium finance agreement is payable.
(b) The service charge shall be a maximum of $12 per $100 per year plus an additional charge not exceeding $20, which additional charge need not be refunded upon prepayment. Such additional charge may be charged only once in a 12-month period for any one customer unless that customer's policy has been canceled due to nonpayment within the immediately preceding 12-month period. However, any insured may prepay her or his premium finance agreement in full at any time before the due date of the final payment; and in such event the unearned service charge shall be refunded in accordance with the "Rule of 78ths," or any other method at least as beneficial to the insured and approved by the office, and shall represent at least as great a proportion of the service charge, if any, as the sum of the periodic balances after the month in which prepayment is made bears to the sum of all periodic balances under the schedule of payments in the agreement. When the amount of the refund is less than $1, no refund need be made if the agreement so states.
(c) Such service charge shall be inclusive of all charges incident to the premium finance agreement and for the extension of credit provided for therein.
(d) Paragraphs (a)-(c) apply if the premiums under only one insurance contract are advanced or to be advanced under a premium finance agreement; if premiums under more than one insurance contract are advanced or to be advanced under a premium finance agreement, the service charge shall be computed from the inception date of such insurance

contracts, or from the due date of such premiums; however, not more than one minimum service charge shall apply to each premium finance agreement.
(e) No insurance agent or premium finance company shall induce an insured to become obligated under more than one premium finance agreement for the purpose of obtaining more than one minimum service charge.

627.841 Delinquency, collection, cancellation, and check return charges; attorney's fees.—
(1) A premium finance agreement may provide for the payment by the insured of a delinquency and collection charge on each installment in default for a period of not less than 5 days in an amount not to exceed $10 or 5 percent of the delinquent installment, whichever is greater; provided that if the premium finance agreement is primarily for personal, family, or household purposes, the delinquency and collection charge shall not exceed $10. Only one such delinquency and collection charge may be collected on any such installment regardless of the period during which it remains in default.
(2) A premium finance agreement may also provide for the payment of attorney's fees not exceeding 20 percent of the amount due and payable under the agreement if it is referred for collection to an attorney not a salaried employee of the premium finance company holding the agreement.
(3) Notwithstanding the provisions of this section, a premium finance company shall not take, receive from, or charge an insured any cancellation charge or attorney's fees unless, within 10 days after default in the payment of any installment of a premium finance agreement, the premium finance company has mailed a notice of the default to the insured at her or his address as shown on the agreement and to any insurance agent named therein at her or his place of business as shown giving the insured at least 5 days within which to make the payment in default.
(4) In the event that a payment is made to a premium finance company by check or draft and the instrument is returned because of insufficient funds to pay it, the premium finance company may, if the premium finance agreement so provides, impose a charge of $15.

627.844 Assignment of premium finance agreement.—
(1) A premium finance company may purchase or otherwise acquire a premium finance agreement from another premium finance company with recourse against the other premium finance company on such terms and conditions as may be mutually agreed upon.
(2) No filing of an assignment or notice thereof to the insured shall be necessary to the validity of the written assignment of a premium finance agreement as against creditors or subsequent purchasers, pledgees, or encumbrancers of the assignor.
(3) Unless the insured has notice of an actual or intended assignment of a premium finance agreement, payment thereunder by the insured to the last known holder of the agreement shall be binding upon all subsequent holders or assignees.

627.845 Statement of account; receipts.—
(1) At any time after the execution of a premium finance agreement, but not later than 1 year after the last payment thereunder, the premium finance company holding the premium finance agreement shall, upon written request of the insured, give or mail to her or him a written statement of the dates and amounts of payments and the total amount, if any, unpaid thereunder. A statement shall be supplied once each year without charge; if any additional statement is requested, the premium finance company shall supply the statement at a charge not exceeding $1 for each additional statement so supplied. An insured shall be given a receipt for a payment when made in cash.
(2) After the payment of all sums for which an insured is obligated under a premium finance agreement, and upon the insured's written demand, the premium finance company holding the agreement shall deliver, or mail to the insured at her or his last known address,

such one or more good and sufficient instruments as may be necessary to acknowledge payment in full and to release all interest in or rights to the insurance contracts, the premiums for which were advanced or are to be advanced under the agreement.

627.848 Cancellation of insurance contract upon default.—
(1) When a premium finance agreement contains a power of attorney or other authority enabling the premium finance company to cancel any insurance contract listed in the agreement, the insurance contract shall not be canceled unless cancellation is in accordance with the following provisions:
(a)1. Not less than 10 days' written notice shall be mailed to each insured shown on the premium finance agreement of the intent of the premium finance company to cancel her or his insurance contract unless the defaulted installment payment is received within 10 days.
2. After expiration of such period, the premium finance company shall mail to the insurer a request for cancellation, specifying the effective date of cancellation and the unpaid premium balance due under the finance contract, and shall mail a copy thereof to the insured at her or his last known address as shown on the premium finance agreement.
(b) Every notice of cancellation shall include, in type or print of which its face shall not be smaller than 12 points, a statement that, if the insurance contract or contracts provide motor vehicle liability insurance required by the financial responsibility law, proof of financial responsibility is required to be maintained continuously for a period of 3 years, pursuant to chapter 324, and the operation of a vehicle without such financial responsibility is unlawful.
(c) Upon receipt of a copy of the cancellation notice by the insurer or insurers, the insurance contract shall be canceled as of the date specified in the cancellation notice with the same force and effect as if the notice of cancellation had been submitted by the insured herself or himself, whether or not the premium finance company has complied with the notice requirement of this subsection, without requiring any further notice to the insured or the return of the insurance contract.
(d) All statutory, regulatory, and contractual restrictions providing that the insured may not cancel her or his insurance contract unless she or he or the insurer first satisfies such restrictions by giving a prescribed notice to a governmental agency, the insurance carrier, a mortgagee, an individual, or a person designated to receive such notice for such governmental agency, insurance carrier, or individual shall apply when cancellation is effected under the provisions of this section. The insurer, in accordance with such prescribed notice when it is required to give such notice in behalf of itself or the insured, shall give notice to such governmental agency, person, mortgagee, or individual; and it shall determine and calculate the effective date of cancellation from the day it receives the copy of the notice of cancellation from the premium finance company.
(e) Whenever a financed insurance contract is canceled, the insurer shall, within 30 days of the cancellation date, return the unpaid balance due under the finance contract, up to the gross amount available upon the cancellation of the policy, to the premium finance company and any remaining unearned premium to the agent or the insured, or both, for the benefit of the insured or insureds. The insurer shall, within 30 days of the cancellation date, notify the insured and the agent of the amount of unearned premium returned to the premium finance company and the amount of unearned commission held by the agent. The premium finance company shall, within 15 days after the account has been overpaid, either refund to the insured for the insured's benefit any refund due on his or her account or, if the refund is sent or credited to the agent, return or credit to the agent the amount of the overpayment and notify the insured of the refunded amount. Within 15 days of receipt of notification from the premium finance company, the agent shall return such amount including any unearned commission to the insured or with the written approval of the insured apply such amount to the purchase of other insurance products regulated by the office. The commission may adopt rules necessary to implement the provisions of this subsection.

(f) If an insurance contract is canceled by an insurer upon the receipt of a copy of the cancellation notice from a premium finance company, and if such premium finance company has failed to provide the notice required by this subsection, the insured shall have a cause of action against the premium finance company for damages caused by such failure to provide notice.
(2) Any court of this state rendering or affirming a judgment or decree against a premium finance company and in favor of any named or omnibus insured or beneficiary arising out of a wrongful or improper cancellation of an insurance policy by such premium finance company shall award reasonable attorney's fees to the insured or beneficiary.
(3) The commission shall adopt a standard cancellation notice for use by premium finance companies in canceling insurance policies. The commission shall specify the color of the notice so as to promote usability and standardization.

627.849 Fees.—
(1) The office shall collect in advance, and the persons so served shall pay to it in advance, the following fees:
(a) Annual license fee.....$250
(b) Investigation fee.....100
(c) Annual report filing fee.....25
(2) The fees received under this section shall be credited to the Insurance Regulatory Trust Fund.

628.4615 Specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.—
(1) For the purposes of this section, the term "specialty insurer" means any person holding a license or certificate of authority as:
(a) A motor vehicle service agreement company authorized to issue motor vehicle service agreements as those terms are defined in s. 634.011;
(b) A home warranty association authorized to issue "home warranties" as those terms are defined in s. 634.301;
(c) A service warranty association authorized to issue "service warranties" as those terms are defined in s. 634.401(13) and (14);
(d) A prepaid limited health service organization authorized to issue prepaid limited health service contracts, as those terms are defined in chapter 636;
(e) An authorized health maintenance organization operating pursuant to s. 641.21;
(f) An authorized prepaid health clinic operating pursuant to s. 641.405;
(g) A legal expense insurance corporation authorized to engage in a legal expense insurance business pursuant to s. 642.021;
(h) A provider that is licensed to operate a facility that undertakes to provide continuing care as those terms are defined in s. 651.011;
(i) A multiple-employer welfare arrangement operating pursuant to ss. 624.436-624.446;
(j) A premium finance company authorized to finance insurance premiums pursuant to s. 627.828; or
(k) A corporation authorized to accept donor annuity agreements pursuant to s. 627.481.
(2) A person may not, individually or in conjunction with any affiliated person of such person, directly or indirectly, conclude a tender offer or exchange offer for, enter into any agreement to exchange securities for, or otherwise finally acquire, 10 percent or more of the outstanding voting securities of a specialty insurer which is a stock corporation or of a controlling company of a specialty insurer which is a stock corporation; or conclude an acquisition of, or otherwise finally acquire, 10 percent or more of the ownership interest of a specialty insurer which is not a stock corporation or of a controlling company of a specialty insurer which is not a stock corporation, unless:

(a) The person or affiliated person has filed with the office and sent by registered mail to the principal office of the specialty insurer and controlling company a letter of notification regarding the transaction or proposed transaction no later than 5 days after any form of tender offer or exchange offer is proposed, or no later than 5 days after the acquisition of the securities or ownership interest if no tender offer or exchange offer is involved. The notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;
(b) The person or affiliated person has filed with the office an application signed under oath and prepared on forms prescribed by the commission which contains the information specified in subsection (4). The application must be completed and filed within 30 days after any form of tender offer or exchange offer is proposed, or after the acquisition of the securities if no tender offer or exchange offer is involved; and
(c) The office has approved the tender offer or exchange offer, or acquisition if no tender offer or exchange offer is involved.
(3) This section does not apply to any acquisition of voting securities or ownership interest of a specialty insurer or of a controlling company by any person who, on July 9, 1986, is the owner of a majority of such voting securities or ownership interest or who, on or after July 9, 1986, becomes the owner of a majority of such voting securities or ownership interest with the approval of the office under this section. The person or affiliated person filing the required notice in paragraph (2)(a) may request the office to waive the requirements of paragraph (2)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the specialty insurer. The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the specialty insurer.
(4) The application to be filed with the office and furnished to the specialty insurer and controlling company shall contain the following information and any additional information as the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the insureds of the insurer and of the public:
(a)1. The identity of, and the background information specified in subsection (5) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and,
2. If the acquisition is to be made by, or on behalf of, a person other than a natural person and as to any person who controls, either directly or indirectly, such other person, the identity of, and the background information specified in subsection (5) on:
a. Each director, officer, or trustee, if a corporation, or
b. Each partner, owner, manager, or joint venturer, or other person performing duties similar to those of persons in the aforementioned positions, if not a corporation,

for the person.

(b) The source and amount of the funds or other consideration used, or to be used, in making the acquisition.
(c) Any plans or proposals which such persons may have made to liquidate the specialty insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management; and any plans or proposals which such persons may have made to liquidate any controlling company of the specialty insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management.
(d) The nature and the extent of the controlling interest which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the

manner in which the controlling interest is to be acquired of a specialty insurer or controlling company which is not a stock corporation.
(e) The number of shares or other securities which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the securities are to be acquired.
(f) Information as to any contract, arrangement, or understanding with any party with respect to any of the securities of the specialty insurer or controlling company, including, but not limited to, information relating to the transfer of any of the securities, option arrangements, puts or calls, or the giving or withholding of proxies, which information names the party with whom the contract, arrangement, or understanding has been entered into and gives the details thereof.
(5)(a) The information as to the background and identity of each natural person, which information is required to be furnished pursuant to paragraph (4)(a), shall include:
1. The natural person's occupations, positions of employment, and offices held during the past 10 years.
2. The principal business and address of any business, corporation, or organization in which each such office of the natural person was held, or in which each such occupation or position of employment was carried on.
3. Whether the natural person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.
4. Whether the natural person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.
5. Whether, during the 10-year period, the natural person has been the subject of any proceeding under the federal [1]Bankruptcy Act; or whether, during the 10-year period, any person or other business or organization in which the natural person was a director, officer, trustee, partner, owner, manager, or other official has been subject to any such proceeding, either during the time in which the natural person was a director, officer, or trustee, if a corporation, or a partner, owner, manager, joint venturer, or other official, if not a corporation, or within 12 months thereafter.
6. Whether, during the 10-year period, the natural person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law regulating the business of insurance, securities, or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities, or banking, together with details as to any such event.
7. Fingerprints of each person referred to in subsection (4).
(b) Any person filing the statement required by this section shall give all required information that is within the knowledge of:
1. The directors, officers, or trustees, if a corporation, or
2. The partners, owners, managers, or joint venturers, or others performing functions similar to those of a director, officer, or trustee, if not a corporation,

of the person making the filing and of any person controlling either directly or indirectly such person. If any material change occurs in the facts set forth in the application filed with the office pursuant to this section, an amendment setting forth such changes shall be filed immediately with the office, and a copy of the amendment shall be sent by registered mail to the principal office of the specialty insurer and to the principal office of the controlling company.

(6)(a) The acquisition application shall be reviewed in accordance with chapter 120. The office may on its own initiate, or, if requested to do so in writing by a substantially affected person, shall conduct, a proceeding to consider the appropriateness of the proposed filing. Time periods for purposes of chapter 120 shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10

days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time it finds an immediate danger to the public health, safety, and welfare of the insureds exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition disapproved and any further steps to conclude the acquisition ceased.

(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the specialty insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the specialty insurer unless advance written notice of the change in management is furnished to the office. A material change in the operation of the specialty insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the specialty insurer. A material change in the management of the specialty insurer is any change in management involving officers or directors of the specialty insurer or any person of the specialty insurer or controlling company having authority to dispose of or obligate 5 percent or more of the specialty insurer's capital or surplus. The office shall approve a material change in operations if it finds the applicable provisions of subsection (8) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (8) have not been met and in such case the specialty insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(7) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:

(a) Willfully violates this section;

(b) In violation of an order of the office issued pursuant to subsection (11), fails to divest himself or herself of any stock or ownership interest obtained in violation of this section or fails to divest himself or herself of any direct or indirect control of such stock or ownership interest, within 25 days after such order; or

(c) In violation of an order issued by the office pursuant to subsection (11), acquires an additional stock or ownership interest in a specialty insurer or controlling company or direct or indirect control of such stock or ownership interest, without complying with this section.

(8) The person or persons filing the application required by subsection (2) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed application if no proceeding is conducted, that:

(a) Upon completion of the acquisition, the specialty insurer will be able to satisfy the requirements for the issuance of a license or certificate to write the line of insurance for which it is presently licensed or certificated.

(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the specialty insurer or prejudice the interests of its insureds or the public.

(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:

1. To liquidate the specialty insurer, sell its assets, or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management, or

2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the specialty insurer,

is fair and free of prejudice to the insureds of the specialty insurer or to the public.

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the specialty insurer indicate that the acquisition is in the best interest of the insureds of the insurer and in the public interest.
(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the insureds of the specialty insurer and in the public interest to permit such persons to exercise control over the specialty insurer.
(f) The directors and officers, if such specialty insurer or controlling company is a stock corporation, or the trustees, partners, owners, managers, or joint venturers or other persons performing duties similar to those of persons in the aforementioned positions, if such specialty insurer or controlling company is not a stock corporation, to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation.
(g) The management of the specialty insurer after the acquisition will be competent and trustworthy, and will possess sufficient managerial experience so as to make the proposed operation of the specialty insurer not hazardous to the insurance-buying public.
(h) The management of the specialty insurer after the acquisition shall not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto.
(i) The acquisition is not likely to be hazardous or prejudicial to the insureds of the insurer or to the public.
(j) The effect of the acquisition would not substantially lessen competition in the line of insurance for which the specialty insurer is licensed or certified in this state or would not tend to create a monopoly therein.
(9) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition contrary to the provisions of this section is void. Upon the petition of the specialty insurer or the controlling company, the circuit court for the county in which the principal office of the specialty insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the provisions of this section. There shall be a private right of action in favor of the specialty insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the specialty insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by the specialty insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of an application pursuant to this section, or who files such an application, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.
(10) Any approval by the office under this section does not constitute a recommendation by the office of the tender offer or exchange offer, or acquisition, if no tender offer or exchange offer is involved. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or

s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.
(11) If the office determines that any person or any affiliated person of such person has acquired 10 percent or more of the outstanding voting securities of a specialty insurer or controlling company which is a stock corporation, or 10 percent or more of the ownership interest of a specialty insurer or controlling company which is not a stock corporation, without complying with the provisions of this section, the office may order that the person and any affiliated person of such person cease acquisition of the specialty insurer or controlling company and, if appropriate, divest itself of any stock or ownership interest acquired in violation of this section.
(12)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any specialty insurer or controlling company acquired in violation of this section.
(b) If any specialty insurer is subject to suspension or revocation pursuant to paragraph (a), the specialty insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its insureds, creditors, or stockholders or to the public.
(13)(a) For the purpose of this section, the term "acquisition" includes:
1. A tender offer or exchange offer for securities, assets, or other ownership interest;
2. An agreement to exchange securities for other securities, assets, or other ownership interest;
3. A merger of a person or affiliated person into a specialty insurer or a merger of any person with a specialty insurer;
4. A consolidation; or
5. Any other form of change of control

whereby any person or affiliated person acquires or attempts to acquire, directly or indirectly, 10 percent or more of the ownership interest or assets of a specialty insurer or of a controlling company. However, in the case of a health maintenance organization organized as a for-profit corporation, the provisions of s. 628.451 shall govern with respect to any merger or consolidation, and, in the case of a health maintenance organization organized as a not-for-profit corporation, the provisions of s. 628.471 shall govern with respect to any merger or consolidation.

(b) For the purpose of this section, the term "affiliated person" of another person includes:
1. The spouse of such other natural person;
2. The parents of such other natural person and their lineal descendants and the parents of such other natural person's spouse and their lineal descendants;
3. Any person who directly or indirectly owns or controls, or holds with power to vote, 10 percent or more of the outstanding voting securities of such other person;
4. Any person who directly or indirectly owns 10 percent or more of the outstanding voting securities which are directly or indirectly owned or controlled, or held with power to vote, by such other person;
5. Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;
6. Any director, officer, trustee, partner, owner, manager, joint venturer, or employee, or other person performing duties similar to those of persons in the aforementioned positions, of such other person;
7. If such other person is an investment company, any investment adviser of such company or any member of an advisory board of such company;
8. If such other person is an unincorporated investment company not having a board of directors, the depositor of such company; or

9. Any person who has entered into an agreement, written or unwritten, to act in concert with such other person in acquiring, or limiting the disposition of, securities of a specialty insurer or controlling company which is a stock corporation or in acquiring, or limiting the disposition of, an ownership interest of a specialty insurer or controlling company which is not a stock corporation.

(c) For the purposes of this section, the term "controlling company" means any corporation, trust, or association owning, directly or indirectly, 25 percent or more of the voting securities of one or more specialty insurance companies which are stock corporations, or 25 percent or more of the ownership interest of one or more specialty insurance companies which are not stock corporations.

(d) For the purpose of this section, the term "natural person" means an individual.

(e) For the purpose of this section, the term "person" includes a natural person, corporation, association, trust, general partnership, limited partnership, joint venture, firm, proprietorship, or any other entity which may hold a license or certificate as a specialty insurer.

(14) The commission may adopt, amend, or repeal rules that are necessary to implement the provisions of this section, pursuant to chapter 120.

690-188

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

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of

any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.470 Annual reports.—
(1)(a) Every self-insurance fund shall, annually within 3 months of the end of the fiscal year, file a financial statement of the fund, including its balance sheet and a statement of operations for the preceding year, verified by the oath of a member of the board of trustees or by an administrative executive appointed by the board. An entry for future investment income, reported on or after January 1, 1998, may only be reflected as an aggregate write-in asset on the balance sheet of the annual and quarterly financial statements. Future investment income shall be calculated as the sum of the admitted asset value of Line 1 (Bonds) plus the admitted asset value of Line 6 (Cash and Short-Term Investments) as reported on page 2 in the annual or quarterly financial statement, times the 3-year treasury note yield as of the date of the financial statement, times 3.
(b) For financial statements filed on or after January 1, 1998, future investment income may only be reported as an admitted asset by an Assessable Mutual or Self-Insurance Fund which reported future investment income in financial statements filed with the [1]Department of Insurance prior to January 1, 1998.
(2) Every fund shall, annually within 6 months of the end of the fiscal year, file a report with the office verified by the oath of a member of the board of trustees or by an administrative executive appointed by the board, containing the following information:
(a) A financial statement of the fund, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant.
(b) A report prepared by an actuary who is a member of the American Academy of Actuaries as to the actuarial soundness of the fund. The report shall consist of, but shall not be limited to, the following:
1. Adequacy of premiums or contributions in paying claims and changes, if any, needed in the contribution rates to achieve or preserve a level of funding deemed adequate, which shall include a valuation of present assets, based on statement value, and prospective assets and liabilities of the plan and the extent of any unfunded accrued liabilities.
2. A plan to amortize any unfunded liabilities and a description of actions taken to reduce unfunded liabilities.
3. A description and explanation of actuarial assumptions.
4. A schedule illustrating the amortization of any unfunded liabilities.

5. A comparative review illustrating the level of funds available to the commercial self-insurance fund from rates, investment income, and other sources realized over the period covered by the report, indicating the assumptions used.
6. A projection of the following year's plan of operation, including additional number of members, gross premiums to be written, and projected liabilities.
7. A statement by the actuary that the report is complete and accurate and that in her or his opinion the techniques and assumptions used are reasonable and meet the requirements of this subsection.
8. Other factors or statements as may be reasonably required by the office or commission in order to determine the actuarial soundness of the plan.
(c) Any changes in the constitution, bylaws, or trust agreement of the fund.

624.474 Assessments.—
(1) The trustees of a self-insurance fund operating as a trust, or the corporate directors of a self-insurance fund operating as a corporation, may assess from time to time members of a self-insurance fund liable therefor under the terms of their policies and pursuant to this section, or the department may assess the members in the event of liquidation of the fund.
(2) Subject to the limitations of s. 624.472(1), each member's share of a deficiency for which an assessment is made shall be computed by applying to the premium earned on the member's policy or policies during the period to be covered by the assessment the ratio of the total deficiency to the total premiums earned during such period upon all policies subject to the assessment. In the event one or more members fail to pay an assessment, the other members are liable on a proportionate basis for an additional assessment. The fund, acting on behalf of all members who paid the additional assessment, shall institute legal action when necessary and appropriate to recover the assessment from members who failed to pay it.
(3) In computing the earned premiums for the purposes of this section, the gross premium received by the fund for the policy shall be used as a base, deducting therefrom solely charges not recurring upon the renewal or extension of the policy.
(4) No member shall have an offset against any assessment for which she or he is liable on account of any claim for unearned premium or losses payable.

624.488 Applicability of related laws.—In addition to other provisions of the code cited in ss. 624.460-624.488:
(1) Sections 624.155, 624.308, 624.414, 624.415, and 624.416(4); ss. 624.418-624.4211, except s. 624.418(2)(f); and s. 624.501;
(2) Parts I, II, and III of chapter 625;
(3) Applicable sections of part VI of chapter 626; s. 626.9541(1)(a), (b), (c), (d), (e), (f), (h), (i), (j), (k), (l), (m), (n), (o), (q), (u), (w), and (x); and ss. 626.9561-626.9641;
(4) Sections 627.291, 627.413, 627.4132, 627.416, 627.418, 627.420, 627.421, 627.425, 627.426, 627.4265, 627.427, 627.428, 627.702, and 627.706; part XI of chapter 627; ss. 627.912, 627.913, and 627.918;
(5) Section 628.361(2) and s. 628.6014; and
(6) Parts I and V of chapter 631,
apply to self-insurance funds. Only those sections of the code that are expressly and specifically cited in ss. 624.460-624.489 apply to self-insurance funds.

690-187

627.357 Medical malpractice self-insurance.—
(1) DEFINITIONS.—As used in this section, the term:
(a) "Fund" means a group or association of health care providers authorized to self-insure.
(b) "Health care provider" means any:
1. Hospital licensed under chapter 395.
2. Physician licensed, or physician assistant licensed, under chapter 458.
3. Osteopathic physician or physician assistant licensed under chapter 459.
4. Podiatric physician licensed under chapter 461.
5. Health maintenance organization certificated under part I of chapter 641.
6. Ambulatory surgical center licensed under chapter 395.
7. Chiropractic physician licensed under chapter 460.
8. Psychologist licensed under chapter 490.
9. Optometrist licensed under chapter 463.
10. Dentist licensed under chapter 466.
11. Pharmacist licensed under chapter 465.
12. Registered nurse, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464.
13. Other medical facility.
14. Professional association, partnership, corporation, joint venture, or other association established by the individuals set forth in subparagraphs 2., 3., 4., 7., 8., 9., 10., 11., and 12. for professional activity.
(c) "Other medical facility" means a facility the primary purpose of which is to provide human medical diagnostic services or a facility providing nonsurgical human medical treatment and in which the patient is admitted to and discharged from such facility within the same working day, and which is not part of a hospital. The term does not include a facility existing for the primary purpose of performing terminations of pregnancies or an office maintained by a physician or dentist for the practice of medicine.
(d) "Hospital subsidiary corporation" means any corporation over which a hospital or the hospital's parent corporation exercises financial or operational control and which provides health care services to the hospital or the hospital parent corporation or another hospital subsidiary corporation.
(e) "Hospital parent corporation" means any corporation which has financial or operational control over a hospital and which provides health care services to the hospital or another hospital subsidiary corporation.
(f) "Committee" means a committee or board of trustees of a health care provider or group of health care providers established to make recommendations, policies, or decisions regarding patient institutional utilization, patient treatment, or institutional staff privileges or to perform other administrative or professional purposes or functions.
(2) A group or association of health care providers composed of any number of members, is authorized to self-insure against claims arising out of the rendering of, or failure to render, medical care or services, or against claims for injury or death to the insured's patients arising out of the insured's activities, upon obtaining approval from the office and upon complying with the following conditions:
(a) Establishment of a Medical Malpractice Risk Management Trust Fund to provide coverage against professional medical malpractice liability.
(b) Employment of professional consultants for loss prevention and claims management coordination under a risk management program.

(3) The fund may insure hospital parent corporations, hospital subsidiary corporations, and committees against claims arising out of the rendering of, or failure to render, medical care or services.
(4) The fund is subject to regulation and investigation by the office. The fund is subject to rules of the commission and to part IX of chapter 626, relating to trade practices and frauds.
(5) The trust fund may purchase medical malpractice insurance, specific excess insurance, and aggregate excess insurance, up to determined limits, as necessary to provide the insurance coverages authorized by this section, consistent with market availability. The trust fund may purchase such risk management services as may be required, pay claims as may arise under any deductible provisions, and engage in prudent investment of trust funds and other activities reasonably relating to the payment of claims and to providing medical malpractice self-insurance, to the extent otherwise consistent with this section and law generally applicable to medical malpractice insurers.
(6) The commission shall adopt rules to implement this section, including rules that ensure that a trust fund remains solvent and maintains a sufficient reserve to cover contingent liabilities under subsection (7) in the event of its dissolution.
(7)(a) The liability of each member for the obligations of the trust fund is individual, several, and proportionate, but not joint, except as provided in this subsection.
(b) Each member has a contingent assessment liability for payment of actual losses and expenses incurred while the member's policy was in force.
(c) The trust fund may from time to time assess members of the fund liable therefor under the terms of their policies and pursuant to this section. The office may assess the members in the event of liquidation of the fund.
(d) A member's share of a deficiency for which an assessment is made is computed by applying to the premium earned on the member's policy or policies during the period to be covered by the assessment the ratio of the total deficiency to the total premiums earned during such period upon all policies subject to the assessment. If one or more members fail to pay an assessment, the other members are liable on a proportionate basis for an additional assessment. The fund, acting on behalf of all members who paid the additional assessment, shall institute legal action, when necessary and appropriate, to recover the assessment from members who failed to pay it.
(e) In computing the earned premiums for the purposes of this section, the gross premium received by the fund for the policy shall be used as a base, deducting therefrom solely charges not recurring upon the renewal or extension of the policy.
(f) No member has an offset against any assessment for which the member is liable, on account of any claim for unearned premium of losses payable.
(g) If the assets of a trust fund are at any time insufficient to comply with the requirements of law, discharge the fund's liabilities, or meet the required conditions of financial soundness, or if a judgment against the fund has remained unsatisfied for 30 days, the trust fund must immediately make up the deficiency or levy an assessment upon the members for the amount needed to make up the deficiency, subject to the limitations set forth in this subsection.
(h) If the trust fund fails to make an assessment as required by paragraph (g), the office shall order the fund to do so. If the deficiency is not sufficiently made up within 60 days after the date of the order, the fund is deemed insolvent and grounds exist to proceed against the fund as provided for in part I of chapter 631.
(i) Subject to this section, any rehabilitation, liquidation, conservation, or dissolution of a trust fund shall be conducted under the supervision of the department, which has all power with respect thereto granted to it under part I of chapter 631 governing the rehabilitation, liquidation, conservation, or dissolution of insurers.
(8) The expense factors associated with rates used by a fund shall be filed with the office at least 30 days prior to use and may not be used until approved by the office. The office

shall disapprove the rates unless the filed expense factors associated therewith are justified and reasonable for the benefits and services provided.
(9) Premiums, contributions, and assessments received by a fund are subject to ss. 624.509(1) and (2) and 624.5092, except that the tax rate is 1.6 percent of the gross amount of such premiums, contributions, or assessments.

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

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

624.424 Annual statement and other information.—

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

627.4147 Medical malpractice insurance contracts.—
(1) In addition to any other requirements imposed by law, each self-insurance policy as authorized under s. 627.357 or s. 624.462 or insurance policy providing coverage for claims arising out of the rendering of, or the failure to render, medical care or services, including those of the Florida Medical Malpractice Joint Underwriting Association, shall include:
(a) A clause requiring the insured to cooperate fully in the review process prescribed under s. 766.106 if a notice of intent to file a claim for medical malpractice is made against the insured.
(b)1. A clause clearly stating whether or not the insured has the exclusive right to veto any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment if the offer is within policy limits. An insurer or self-insurer shall not make or conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if such offer is outside the policy limits. However, any offer for admission of liability and for arbitration made under s. 766.106, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interest of the insured.
2. If the policy contains a clause stating the insured does not have the exclusive right to veto any offer or admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment, the insurer or self-insurer shall provide to the insured or the insured's legal representative by certified mail, return receipt requested, a copy of the final offer of admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment and at the same time such offer is provided to the claimant. A copy of any final agreement reached between the insurer and claimant shall also be provided to the insurer or his or her legal representative by certified mail, return receipt requested not more than 10 days after affecting such agreement.

(c) A clause requiring the insurer or self-insurer to notify the insured no less than 90 days prior to the effective date of cancellation of the policy or contract and, in the event of a determination by the insurer or self-insurer not to renew the policy or contract, to notify the insured no less than 90 days prior to the end of the policy or contract period. If cancellation or nonrenewal is due to nonpayment or loss of license, 10 days' notice is required.
(d) A clause requiring the insurer or self-insurer to notify the insured no less than 60 days prior to the effective date of a rate increase. The provisions of s. 627.4133 shall apply to such notice and to the failure of the insurer to provide such notice to the extent not in conflict with this section.
(2) Each insurer covered by this section may require the insured to be a member in good standing, i.e., not subject to expulsion or suspension, of a duly recognized state or local professional society of health care providers which maintains a medical review committee. No professional society shall expel or suspend a member solely because he or she participates in a health maintenance organization licensed under part I of chapter 641.
(3) This section shall apply to all policies issued or renewed after October 1, 2003.

627.4148 Medical malpractice insurers; required offer of coverage limits.—An insurer issuing policies of professional liability coverage for claims arising out of the rendering of, or the failure to render, medical care or services shall make available to physicians licensed under chapter 458 and to osteopathic physicians licensed under chapter 459 coverage with the following limits, subject to usual underwriting standards:
(1) One hundred thousand dollars per claim, $300,000 annual aggregate; and
(2) Two hundred fifty thousand dollars per claim, $750,000 annual aggregate.

690-170

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

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

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of

any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

625.091 Losses and loss adjustment expense reserves; liability insurance and workers' compensation insurance.—The reserve liabilities recorded in the insurer's annual statement and financial statements for unpaid losses and loss adjustment expenses shall be the estimated value of its claims when ultimately settled and shall be computed as follows:
(1) For all liability and workers' compensation claims, the statement and statutory reserves and loss adjustment expenses shall be in accordance with the form of the annual statement as required in s. 624.424, and shall include the computed, determined, or estimated value of the unpaid reported claims and loss adjustment expenses, allocated and unallocated, and a provision for loss and loss adjustment expenses, allocated and unallocated, that are incurred but not reported. For claims under liability policies, the reserve for reported claims shall not be less than $1,000 for each outstanding liability suit.
(2)(a) Workers' compensation tabular reserves and long-term disability claims including death claims may be reserved at the present value at 4 percent interest of the determined and the estimated future payments.
(b) If workers' compensation reserves are discounted in accordance with paragraph (a), discounted loss and loss expense reserves shall be used in the computation of excess statutory reserves over statement reserves.
(3) Structured settlements may be used to reduce reserves if:
(a) There is the purchase of an annuity by the insurer to fund future payments that are fixed or determined by settlement provisions or statutes wherein the claimant is the payee, the transaction may be treated as a paid claim and the reserve taken down accordingly. The appropriate disclosure of the contingent liability for such amount must be disclosed in notes to the financial statements of the annual statement; or
(b) The insurer assigns the obligation to make periodic payments to a third party and obtains a full and complete release from the claimant, the claim may be treated as a paid claim without additional disclosure.
(4)(a) Accounting credit for anticipated recoveries from the Special Disability Trust Fund may only be taken in the determination of loss reserves and may not be reflected on the financial statements in any manner other than that allowed pursuant to this subsection.
(b)1. For calendar years 1999-2003, an insurer recording anticipated recoveries from the Special Disability Trust Fund shall limit the aggregate amount to the amount management reasonably expects will be reimbursed or the following amount, whichever is lower:

a. For financial statements filed in 2000, an insurer may take accounting credit in an amount equaling 80 percent of the amount utilized in calendar year 1996.
b. For financial statements filed in 2001, an insurer may take accounting credit in an amount equaling 60 percent of the amount utilized in calendar year 1996.
c. For financial statements filed in 2002, an insurer may take accounting credit in an amount equaling 40 percent of the amount utilized in calendar year 1996.
d. For financial statements filed in 2003, an insurer may take accounting credit in an amount equaling 20 percent of the amount utilized in calendar year 1996.
2. Subparagraph 1. does not apply to an insurer recording anticipated recoveries from the Special Disability Trust Fund on the basis of:
a. A proof of claim which the fund has reviewed, determined to be a valid claim and so notified the carrier, and extended a payment offer; or
b. A reimbursement request audited and approved for payment or paid by the fund;
(c) Beginning with financial statements filed in 2004, an insurer may only take accounting credit for anticipated recoveries from the Special Disability Trust Fund for each proof of claim which the fund has reviewed, determined to be a valid claim and so notified the carrier, and extended a payment offer; or a reimbursement request audited and approved for payment or paid by the fund.
(d)1. Beginning in calendar year 1998, each insurer shall separately identify anticipated recoveries from the Special Disability Trust Fund on the annual statement required to be filed pursuant to s. 624.424.
2. For all financial statements filed with the office, each insurer shall disclose in the notes to the financial statements of any financial statement required to be filed pursuant to s. 624.424 any credit in loss reserves taken for anticipated recoveries from the Special Disability Trust Fund. That disclosure shall include:
a. The amount of credit taken by the insurer in the determination of its loss reserves for the prior calendar year and the current reporting period on a year-to-date basis.
b. The amount of payments received by the insurer from the Special Disability Trust Fund during the prior calendar year and the year-to-date recoveries for the current year.
c. The amount the insurer was assessed by the Special Disability Trust Fund during the prior calendar year and during the current calendar year.

690-138

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.316 Examination of insurers.—
(1)(a) The office shall examine the affairs, transactions, accounts, records, and assets of each authorized insurer and of the attorney in fact of a reciprocal insurer as to its transactions affecting the insurer as often as it deems advisable, except as provided in this section. The examination may include examination of the affairs, transactions, accounts, and records relating directly or indirectly to the insurer and of the assets of the insurer's managing general agents and controlling or controlled person, as defined in s. 625.012. The examination shall be pursuant to a written order of the office. Such order shall expire upon receipt by the office of the written report of the examination.
(b) As a part of its examination procedure, the office shall examine each insurer regarding all of the information required by s. 627.915.
(c) The office shall examine each insurer according to accounting procedures designed to fulfill the requirements of generally accepted insurance accounting principles and practices and good internal control and in keeping with generally accepted accounting forms, accounts, records, methods, and practices relating to insurers. To facilitate uniformity in examinations, the commission may adopt, by rule, the Market Conduct Examiners Handbook and the Financial Condition Examiners Handbook of the National Association of Insurance Commissioners, 2002, and may adopt subsequent amendments thereto, if the examination methodology remains substantially consistent.
(2)(a) Except as provided in paragraph (f), the office may examine each insurer as often as may be warranted for the protection of the policyholders and in the public interest, and shall examine each domestic insurer not less frequently than once every 5 years. The examination shall cover the preceding 5 fiscal years of the insurer and shall be commenced within 12 months after the end of the most recent fiscal year being covered by the examination. The examination may cover any period of the insurer's operations since the last previous examination. The examination may include examination of events subsequent to the end of the most recent fiscal year and the events of any prior period that affect the present financial condition of the insurer.
(b) The office shall examine each insurer applying for an initial certificate of authority to transact insurance in this state before granting the initial certificate.
(c) In lieu of making its own examination, the office may accept a full report of the last recent examination of a foreign insurer, certified to by the insurance supervisory official of another state.
(d) The examination by the office of an alien insurer shall be limited to the alien insurer's insurance transactions and affairs in the United States, except as otherwise required by the office.
(e) The commission shall adopt rules providing that an examination under this section may be conducted by independent certified public accountants, actuaries, investment specialists, information technology specialists, and reinsurance specialists meeting criteria specified by rule. The rules shall provide:

1. That the rates charged to the insurer being examined are consistent with rates charged by other firms in a similar profession and are comparable with the rates charged for comparable examinations.
2. That the firm selected by the office to perform the examination has no conflicts of interest that might affect its ability to independently perform its responsibilities on the examination.
3. That the insurer being examined must make payment for the examination pursuant to s. 624.320(1) in accordance with the rates and terms established by the office and the firm performing the examination.
(f) An examination under this section must be conducted at least once every year with respect to a domestic insurer that has continuously held a certificate of authority for less than 3 years. The examination must cover the preceding fiscal year or the period since the last examination of the insurer. The office may limit the scope of the examination.

625.121 Standard Valuation Law; life insurance.—

(3) ACTUARIAL OPINION OF RESERVES.—
(a) Each life insurer doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commission by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commission by rule shall define the specifics of this opinion and add any other items determined necessary to its scope.
1. The opinion shall be submitted with the annual statement and must reflect the valuation of such reserve liabilities for each year ending on or before December 31 of the year before the operative date of the valuation manual as defined in s. 625.1212(2), and in accordance with s. 625.1212(4) for each year thereafter.
2. The opinion applies to all business in force, including individual and group health insurance plans, in the form and substance acceptable to the office as specified by rule of the commission.
3. The commission may adopt rules providing the standards of the actuarial opinion consistent with standards adopted by the Actuarial Standards Board on December 31, 2013, and subsequent revisions thereto if the standards remain substantially consistent.
4. The office may accept an opinion filed by a foreign or alien insurer with the insurance supervisory official of another state if the office determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in this state.
5. As used in this subsection, the term "qualified actuary" means a member in good standing of the American Academy of Actuaries who also meets the requirements specified by rule of the commission.
6. Disciplinary action by the office against the insurer or the qualified actuary shall be in accordance with the insurance code and related rules adopted by the commission.
7. A memorandum in the form and substance specified by rule shall be prepared to support each actuarial opinion.
8. If the insurer fails to provide a supporting memorandum at the request of the office within a period specified by rule of the commission, or if the office determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by rule of the commission, the office may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare such supporting memorandum as required by the office.
9. Except as otherwise provided in this subparagraph, any memorandum or other material in support of the opinion is confidential and exempt from s. 119.07(1) and is not subject to

subpoena or discovery directly from the office; however, the memorandum or other material may be released by the office with the written consent of the insurer, or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the office for preserving the confidentiality of the memorandum or other material. If any portion of the confidential memorandum is cited by the insurer in its marketing, is cited before any governmental agency other than a state insurance department, or is released by the insurer to the news media, no portion of the memorandum is confidential. Neither the office nor any person who receives documents, materials, or other information while acting under the authority of the office or with whom such information is shared pursuant to this paragraph may testify in a private civil action concerning the confidential documents, materials, or information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. A waiver of an applicable privilege or claim of confidentiality in the documents, materials, or information may not occur as a result of disclosure to the office under this section or any other section of the insurance code, or as a result of sharing as authorized under s. 624.4212.

(b) In addition to the opinion required by paragraph (a), the office may, pursuant to commission rule, require an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commission by rule, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts, including, but not limited to, the benefits under, and expenses associated with, the policies and contracts.

(c) The commission may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this subsection.

624.307 General powers; duties.—

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

624.3161 Market conduct examinations.—

(1) As often as it deems necessary, the office shall examine each licensed rating organization, each advisory organization, each group, association, carrier, as defined in s. 440.02, or other organization of insurers which engages in joint underwriting or joint reinsurance, and each authorized insurer transacting in this state any class of insurance to which the provisions of chapter 627 are applicable. The examination shall be for the purpose of ascertaining compliance by the person examined with the applicable provisions of chapters 440, 624, 626, 627, and 635.

(2) In lieu of any such examination, the office may accept the report of a similar examination made by the insurance supervisory official of another state.

(3) The examination may be conducted by an independent professional examiner under contract to the office, in which case payment shall be made directly to the contracted examiner by the insurer examined in accordance with the rates and terms agreed to by the office and the examiner.

(4) The reasonable cost of the examination shall be paid by the person examined, and such person shall be subject, as though an insurer, to the provisions of s. 624.320.

(5) Such examinations shall also be subject to the applicable provisions of chapter 440 and ss. 624.318, 624.319, 624.321, and 624.322.
(6) Based on the findings of a market conduct examination that an insurer has exhibited a pattern or practice of willful violations of an unfair insurance trade practice related to claims-handling which caused harm to policyholders, as prohibited by s. 626.9541(1)(i), the office may order an insurer pursuant to chapter 120 to file its claims-handling practices and procedures related to that line of insurance with the office for review and inspection, to be held by the office for the following 36-month period. Such claims-handling practices and procedures are public records and are not trade secrets or otherwise exempt from the provisions of s. 119.07(1). As used in this section, "claims-handling practices and procedures" are any policies, guidelines, rules, protocols, standard operating procedures, instructions, or directives that govern or guide how and the manner in which an insured's claims for benefits under any policy will be processed.

624.320 Examination expenses.—
(1) Each insurer so examined shall pay to the office the expenses of the examination at the rates adopted by the office. Such expenses shall include actual travel expenses, reasonable living expense allowance, compensation of the examiner or other person making the examination, and necessary attendant administrative costs of the office directly related to the examination. Such travel expense and living expense allowance shall be limited to those expenses necessarily incurred on account of the examination and shall be paid by the examined insurer together with compensation upon presentation by the office to such insurer of a detailed account of such charges and expenses after a detailed statement has been filed by the examiner and approved by the office.
(2) All moneys collected from insurers for examinations shall be deposited into the Insurance Regulatory Trust Fund, and the office may make deposits from time to time into such fund from moneys appropriated for the operation of the office.
(3) Notwithstanding the provisions of s. 112.061, the office may pay to the examiner or person making the examination out of such trust fund the actual travel expenses, reasonable living expense allowance, and compensation in accordance with the statement filed with the office by the examiner or other person, as provided in subsection (1) upon approval by the office.
(4) When not examining an insurer, the travel expenses, per diem, and compensation for the examiners and other persons employed to make examinations, if approved, shall be paid out of moneys budgeted for such purpose as regular employees, reimbursements for such travel expenses and per diem to be at rates no more than as provided in s. 112.061.
(5) The office may pay to regular insurance examiners, not residents of Leon County, Florida, per diem for periods not exceeding 30 days for each such examiner while at the Office of Insurance Regulation in Tallahassee, Florida, for the purpose of auditing insurers' annual statements. Such expenses shall be paid out of moneys budgeted for such purpose, as for regular employees at rates provided in s. 112.061.
(6) The provisions of this section shall apply to rate analysts and rate examiners in the discharge of their duties under s. 624.3161.

624.321 Witnesses and evidence.—
(1) As to any examination, investigation, or hearing being conducted under this code, a person designated by the department or office, respectively:
(a) May administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence; and

(b) Shall have the power to subpoena witnesses, compel their attendance and testimony, and require by subpoena the production of books, papers, records, files, correspondence, documents, or other evidence which is relevant to the inquiry.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as

its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

625.331 Special consent investments.—
(1) After satisfying the requirements of this part, any funds of an insurer in excess of its reserves and policyholders' surplus required to be maintained may be invested:
(a) Without limitation in any investments otherwise authorized by this part; or
(b) In such other investments not specifically authorized by this part as long as such investments do not exceed the lesser of 5 percent of the insurer's total admitted assets or 25 percent of the amount by which the insurer's policyholders' surplus exceeds the minimum required to be maintained.

The limitations in paragraph (b) may be exceeded if consented to in writing by the office.

(2) In no case shall the investments authorized under this section being held by an insurer be greater than the amount by which the insurer's policyholders' surplus exceeds the minimum required to be maintained.
(3) Notwithstanding the provisions of this section, an insurer may not invest in investments prohibited by this code.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.
(2) The department shall have the powers and authority expressly conferred upon it by, or reasonably implied from, the provisions of this code. The office shall have the powers and authority expressly conferred upon it by, or reasonably implied from, the provisions of this code.
(3) The department or office may conduct such investigations of insurance matters, in addition to investigations expressly authorized, as it may deem proper to determine whether any person has violated any provision of this code within its respective regulatory jurisdiction or to secure information useful in the lawful administration of any such provision. The cost of such investigations shall be borne by the state.
(4) The department and office may each collect, propose, publish, and disseminate information relating to the subject matter of any duties imposed upon it by law.
(5) The department and office shall each have such additional powers and duties as may be provided by other laws of this state.
(6) The department and office may each employ actuaries who shall be at-will employees and who shall serve at the pleasure of the Chief Financial Officer, in the case of department employees, or at the pleasure of the director of the office, in the case of office employees. Actuaries employed pursuant to this paragraph shall be members of the Society of Actuaries or the Casualty Actuarial Society and shall be exempt from the Career Service System established under chapter 110. The salaries of the actuaries employed pursuant to this paragraph shall be set in accordance with [1]s. 216.251(2)(a)5. and shall be set at levels which are commensurate with salary levels paid to actuaries by the insurance industry.
(7) The office, within existing resources, may expend funds for the professional development of its employees, including, but not limited to, professional dues for employees who are required to be members of professional organizations; examinations leading to professional designations required for employment with the office; training courses and examinations provided through, and to ensure compliance with, the National Association of Insurance Commissioners; or other training courses related to the regulation of insurance.
(8) The office shall, within existing resources, develop and implement an outreach program for the purpose of encouraging the entry of additional insurers into the Florida market.
(9) Upon receiving service of legal process issued in any civil action or proceeding in this state against any regulated person or any unauthorized insurer under s. 626.906 or s. 626.937 which is required to appoint the Chief Financial Officer as its attorney to receive service of all legal process, the Chief Financial Officer, as attorney, may, in lieu of sending the process by registered or certified mail, send the process or make it available by any other verifiable means, including, but not limited to, making the documents available by electronic transmission from a secure website established by the department to the person last designated by the regulated person or the unauthorized insurer to receive the process. When process documents are made available electronically, the Chief Financial Officer shall send a notice of receipt of service of process to the person last designated by the regulated person or unauthorized insurer to receive legal process. The notice must state the date and manner in which the copy of the process was made available to the regulated person or unauthorized insurer being served and contain the uniform resource locator (URL) for a hyperlink to access files and information on the department's website to obtain a copy of the process.
(10)(a) The Division of Consumer Services shall perform the following functions concerning products or services regulated by the department or office:
1. Receive inquiries and complaints from consumers.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.
(2) The department shall have the powers and authority expressly conferred upon it by, or reasonably implied from, the provisions of this code. The office shall have the powers and authority expressly conferred upon it by, or reasonably implied from, the provisions of this code.
(3) The department or office may conduct such investigations of insurance matters, in addition to investigations expressly authorized, as it may deem proper to determine whether any person has violated any provision of this code within its respective regulatory jurisdiction or to secure information useful in the lawful administration of any such provision. The cost of such investigations shall be borne by the state.
(4) The department and office may each collect, propose, publish, and disseminate information relating to the subject matter of any duties imposed upon it by law.
(5) The department and office shall each have such additional powers and duties as may be provided by other laws of this state.
(6) The department and office may each employ actuaries who shall be at-will employees and who shall serve at the pleasure of the Chief Financial Officer, in the case of department employees, or at the pleasure of the director of the office, in the case of office employees. Actuaries employed pursuant to this paragraph shall be members of the Society of Actuaries or the Casualty Actuarial Society and shall be exempt from the Career Service System established under chapter 110. The salaries of the actuaries employed pursuant to this paragraph shall be set in accordance with [1]s. 216.251(2)(a)5. and shall be set at levels which are commensurate with salary levels paid to actuaries by the insurance industry.
(7) The office, within existing resources, may expend funds for the professional development of its employees, including, but not limited to, professional dues for employees who are required to be members of professional organizations; examinations leading to professional designations required for employment with the office; training courses and examinations provided through, and to ensure compliance with, the National Association of Insurance Commissioners; or other training courses related to the regulation of insurance.
(8) The office shall, within existing resources, develop and implement an outreach program for the purpose of encouraging the entry of additional insurers into the Florida market.
(9) Upon receiving service of legal process issued in any civil action or proceeding in this state against any regulated person or any unauthorized insurer under s. 626.906 or s. 626.937 which is required to appoint the Chief Financial Officer as its attorney to receive service of all legal process, the Chief Financial Officer, as attorney, may, in lieu of sending the process by registered or certified mail, send the process or make it available by any other verifiable means, including, but not limited to, making the documents available by electronic transmission from a secure website established by the department to the person last designated by the regulated person or the unauthorized insurer to receive the process. When process documents are made available electronically, the Chief Financial Officer shall send a notice of receipt of service of process to the person last designated by the regulated person or unauthorized insurer to receive legal process. The notice must state the date and manner in which the copy of the process was made available to the regulated person or unauthorized insurer being served and contain the uniform resource locator (URL) for a hyperlink to access files and information on the department's website to obtain a copy of the process.
(10)(a) The Division of Consumer Services shall perform the following functions concerning products or services regulated by the department or office:
1. Receive inquiries and complaints from consumers.

2. Prepare and disseminate information that the department deems appropriate to inform or assist consumers.
3. Provide direct assistance to and advocacy for consumers who request such assistance or advocacy.
4. With respect to apparent or potential violations of law or applicable rules committed by a person or entity licensed by the department or office, report apparent or potential violations to the office or to the appropriate division of the department, which may take any additional action it deems appropriate.
5. Designate an employee of the division as the primary contact for consumers on issues relating to sinkholes.

(b) Any person licensed or issued a certificate of authority by the department or the office shall respond, in writing, to the division within 20 days after receipt of a written request for information from the division concerning a consumer complaint. The division may impose an administrative penalty for failure to comply with this paragraph of up to $2,500 per violation upon any entity licensed by the department or the office and $250 for the first violation, $500 for the second violation, and up to $1,000 for the third or subsequent violation upon any individual licensed by the department or the office.

(c) The department may adopt rules to administer this subsection.

(d) The powers, duties, and responsibilities expressed or granted in this subsection do not limit the powers, duties, and responsibilities of the department, the Financial Services Commission, the Office of Insurance Regulation, or the Office of Financial Regulation as otherwise provided by law.

624.308 Rules.—

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

624.424 Annual statement and other information.—

(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain:

1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require

semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the

insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is

immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.

(f) Number of new policies written.

(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:

1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).

2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.

3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

627.062 Rate standards.—

(1) The rates for all classes of insurance to which the provisions of this part are applicable may not be excessive, inadequate, or unfairly discriminatory.

(2) As to all such classes of insurance:

(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals that allow the insurer a reasonable rate of return on the classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, must be filed with the office under one of the following procedures:

1. If the filing is made at least 90 days before the proposed effective date and is not implemented during the office's review of the filing and any proceeding and judicial review, such filing is considered a "file and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings does not toll the 90-day

period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.

2. If the filing is not made in accordance with subparagraph 1., such filing must be made as soon as practicable, but within 30 days after the effective date, and is considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders those portions of rates found to be excessive, as provided in paragraph (h).

3. For all property insurance filings made or submitted after January 25, 2007, but before May 1, 2012, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered property coverages.

(b) Upon receiving a rate filing, the office shall review the filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:

1. Past and prospective loss experience within and without this state.
2. Past and prospective expenses.
3. The degree of competition among insurers for the risk insured.
4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers calculate investment income attributable to classes of insurance written in this state and the manner in which investment income is used to calculate insurance rates. Such manner must contemplate allowances for an underwriting profit factor and full consideration of investment income that produces a reasonable rate of return; however, investment income from invested surplus may not be considered.
5. The reasonableness of the judgment reflected in the filing.
6. Dividends, savings, or unabsorbed premium deposits allowed or returned to policyholders, members, or subscribers in this state.
7. The adequacy of loss reserves.
8. The cost of reinsurance. The office may not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer's estimated 250-year probable maximum loss or any lower level of loss.
9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.
10. Conflagration and catastrophe hazards, if applicable.
11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.
12. Projected flood losses for personal residential property insurance, if applicable, which may be estimated using a model or method, or a straight average of model results or output ranges, independently found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology and as further provided in s. 627.0628.
13. A reasonable margin for underwriting profit and contingencies.
14. The cost of medical services, if applicable.
15. Other relevant factors that affect the frequency or severity of claims or expenses.

(c) In the case of fire insurance rates, consideration must be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.

(d) If conflagration or catastrophe hazards are considered by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and maintain the premium in a catastrophe reserve. Removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes must be approved by the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes must be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), the office may find a rate to be excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business which is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.
2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, if the replenishment is attributable to investment losses.
3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.
4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625.
5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.
6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.

(f) In reviewing a rate filing, the office may require the insurer to provide, at the insurer's expense, all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.

(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being notified, the insurer or rating organization shall, within 60 days, file with the office all information that, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer may not alter the rate except to conform to the office's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of implementing the rate. The office, subject to chapter 120, may disapprove without the 60-day notification any rate increase

filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(h) If the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule, which responds to the findings of the office, be filed by the insurer. The office shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to the policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding is applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(i) Except as otherwise specifically provided in this chapter, for property and casualty insurance the office may not directly or indirectly:

1. Prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing; or

2. Impede, abridge, or otherwise compromise an insurer's right to acquire policyholders, advertise, or appoint agents, including the calculation, manner, or amount of such agent commissions, if any.

(j) With respect to residential property insurance rate filings, the rate filing must account for mitigation measures undertaken by policyholders to reduce hurricane losses.

(k)1. A residential property insurer may make a separate filing limited solely to an adjustment of its rates for reinsurance, the cost of financing products used as a replacement for reinsurance, financing costs incurred in the purchase of reinsurance, and the actual cost paid due to the application of the cash build-up factor pursuant to s. 215.555(5)(b) if the insurer:

a. Elects to purchase financing products such as a liquidity instrument or line of credit, in which case the cost included in filing for the liquidity instrument or line of credit may not result in a premium increase exceeding 3 percent for any individual policyholder. All costs contained in the filing may not result in an overall premium increase of more than 15 percent for any individual policyholder.

b. Includes in the filing a copy of all of its reinsurance, liquidity instrument, or line of credit contracts; proof of the billing or payment for the contracts; and the calculation upon which the proposed rate change is based demonstrating that the costs meet the criteria of this section.

2. An insurer that purchases reinsurance or financing products from an affiliated company may make a separate filing only if the costs for such reinsurance or financing products are charged at or below charges made for comparable coverage by nonaffiliated reinsurers or financial entities making such coverage or financing products available in this state.

3. An insurer may make only one filing per 12-month period under this paragraph.

4. An insurer that elects to implement a rate change under this paragraph must file its rate filing with the office at least 45 days before the effective date of the rate change. After an insurer submits a complete filing that meets all of the requirements of this paragraph, the office has 45 days after the date of the filing to review the rate filing and determine if the rate is excessive, inadequate, or unfairly discriminatory.

The provisions of this subsection do not apply to workers' compensation, employer's liability insurance, and motor vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules filed with the office and that have been submitted to the insurer for individual rating, the insurer must maintain documentation on

each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for at least 5 years after the effective date of the policy.

(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.

(c) This subsection does not apply to private passenger motor vehicle insurance.

(d)1. The following categories or kinds of insurance and types of commercial lines risks are not subject to paragraph (2)(a) or paragraph (2)(f):

a. Excess or umbrella.

b. Surety and fidelity.

c. Boiler and machinery and leakage and fire extinguishing equipment.

d. Errors and omissions.

e. Directors and officers, employment practices, fiduciary liability, and management liability.

f. Intellectual property and patent infringement liability.

g. Advertising injury and Internet liability insurance.

h. Property risks rated under a highly protected risks rating plan.

i. General liability.

j. Nonresidential property, except for collateral protection insurance as defined in s. 624.6085.

k. Nonresidential multiperil.

l. Excess property.

m. Burglary and theft.

n. Travel insurance, if issued as a master group policy with a situs in another state where each certificateholder pays less than $30 in premium for each covered trip and where the insurer has written less than $1 million in annual written premiums in the travel insurance product in this state during the most recent calendar year.

o. Medical malpractice for a facility that is not a hospital licensed under chapter 395, a nursing home licensed under part II of chapter 400, or an assisted living facility licensed under part I of chapter 429.

p. Medical malpractice for a health care practitioner who is not a dentist licensed under chapter 466, a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, a pharmacist licensed under chapter 465, or a pharmacy technician registered under chapter 465.

q. Any other commercial lines categories or kinds of insurance or types of commercial lines risks that the office determines should not be subject to paragraph (2)(a) or paragraph (2)(f) because of the existence of a competitive market for such insurance or similarity of such insurance to other categories or kinds of insurance not subject to paragraph (2)(a) or paragraph (2)(f), or to improve the general operational efficiency of the office.

2. Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on insurance and risks described in subparagraph 1. which are written in this state.

3. An insurer shall notify the office of any changes to rates for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the insurer, the type or kind of insurance subject to rate change, and the average statewide percentage change in rates. Actuarial data with regard to rates for such risks must be maintained by the insurer for 2 years after the effective date

of changes to those rates and are subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b), (c), and (d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

4. A rating organization shall notify the office of any changes to loss cost for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to paragraph (2)(a) or paragraph (2)(f) must be maintained by the rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b)-(d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

(4) The establishment of any rate, rating classification, rating plan or schedule, or variation thereof in violation of part IX of chapter 626 is also in violation of this section.

(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the fund, together with reasonable costs of other reinsurance; however, except as otherwise provided in this section, the insurer may not recoup reinsurance costs that duplicate coverage provided by the fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium, and any over-recoupment must be subtracted from the following year's reimbursement premium.

(6)(a) If an insurer requests an administrative hearing pursuant to s. 120.57 related to a rate filing under this section, the director of the Division of Administrative Hearings shall expedite the hearing and assign an administrative law judge who shall commence the hearing within 30 days after the receipt of the formal request and enter a recommended order within 30 days after the hearing or within 30 days after receipt of the hearing transcript by the administrative law judge, whichever is later. Each party shall have 10 days in which to submit written exceptions to the recommended order. The office shall enter a final order within 30 days after the entry of the recommended order. The provisions of this paragraph may be waived upon stipulation of all parties.

(b) Upon entry of a final order, the insurer may request an expedited appellate review pursuant to the Florida Rules of Appellate Procedure. It is the intent of the Legislature that the First District Court of Appeal grant an insurer's request for an expedited appellate review.

(7) The provisions of this subsection apply only to rates for medical malpractice insurance and control to the extent of any conflict with other provisions of this section.

(a) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base and used to justify a rate or rate change. Any common-law bad faith action identified as such, any portion of a settlement entered as a result of a statutory or common-law action, or any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages may not be included in the insurer's rate base and used to justify a rate or rate change.

(b) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, using loss experience solely for this state or giving greater credibility to this state's loss data after applying actuarially sound methods of assigning credibility to such data.
(c) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.
(d) The insurer must apply a discount or surcharge based on the health care provider's loss experience or establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used, and provide a copy, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.
(e) For medical malpractice rates subject to paragraph (2)(a), the medical malpractice insurer shall make a rate filing under this section, sworn to by at least two executive officers of the insurer, at least once each calendar year.
(8)(a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a property rate filing subject to paragraph (2)(a):
1. The signing officer and actuary have reviewed the rate filing;
2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading;
3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and
4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.
(b) A signing officer or actuary who knowingly makes a false certification under this subsection commits a violation of s. 626.9541(1)(e) and is subject to the penalties under s. 626.9521.
(c) Failure to provide such certification by the officer and actuary shall result in the rate filing being disapproved without prejudice to be refiled.
(d) The certification made pursuant to paragraph (a) is not rendered false if, after making the subject rate filing, the insurer provides the office with additional or supplementary information pursuant to a formal or informal request from the office. However, the actuary who is primarily responsible for preparing and submitting such information must certify the information in accordance with the certification required under paragraph (a) and the penalties in paragraph (b), except that the chief executive officer, chief financial officer, or chief actuary need not certify the additional or supplementary information.
(e) The commission may adopt rules and forms to administer this subsection.
(9) The burden is on the office to establish that rates are excessive for personal lines residential coverage with a dwelling replacement cost of $1 million or more or for a single condominium unit with a combined dwelling and contents replacement cost of $1 million or more. Upon request of the office, the insurer shall provide such loss and expense information as the office reasonably needs to meet this burden.
(10) Any interest paid pursuant to s. 627.70131(5) may not be included in the insurer's rate base and may not be used to justify a rate or rate change

627.0651 Making and use of rates for motor vehicle insurance.—
(1) Insurers shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on motor vehicle insurance written in this state. A copy of rates, rating schedules, and rating manuals, and changes therein, shall be filed with the office under one of the following procedures:
(a) If the filing is made at least 60 days before the proposed effective date and the filing is not implemented during the office's review of the filing and any proceeding and judicial review, such filing shall be considered a "file and use" filing. In such case, the office shall initiate proceedings to disapprove the rate and so notify the insurer or shall finalize its review within 60 days after receipt of the filing. Notification to the insurer by the office of its preliminary findings shall toll the 60-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue notice to the insurer of its preliminary findings within 60 days after the filing.
(b) If the filing is not made in accordance with the provisions of paragraph (a), such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders portions of rates found to be excessive, as provided in subsection (11).
(2) Upon receiving notice of a rate filing or rate change, the office shall review the rate or rate change to determine if the rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall in accordance with generally accepted and reasonable actuarial techniques consider the following factors:
(a) Past and prospective loss experience within and outside this state.
(b) The past and prospective expenses.
(c) The degree of competition among insurers for the risk insured.
(d) Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. Such investment income shall not include income from invested surplus. The commission may adopt rules utilizing reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to motor vehicle insurance policies written in this state and the manner in which such investment income is used in the calculation of insurance rates. Such manner shall contemplate the use of a positive underwriting profit allowance in the rates that will be compatible with a reasonable rate of return plus provisions for contingencies. The total of the profit and contingency factor as specified in the filing shall be utilized in computing excess profits in conjunction with s. 627.066. In adopting such rules, the commission shall in all instances adhere to and implement the provisions of this paragraph.
(e) The reasonableness of the judgment reflected in the filing.
(f) Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.
(g) The cost of repairs to motor vehicles.
(h) The cost of medical services, if applicable.
(i) The adequacy of loss reserves.
(j) The cost of reinsurance.
(k) Trend factors, including trends in actual losses per insured unit for the insurer making the filing.
(l) Other relevant factors which impact upon the frequency or severity of claims or upon expenses.
(3) Rates shall be deemed excessive if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.

(4) Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, when such replenishment is attributable to investment losses.

(5)(a) Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

(b) The office has the responsibility to ensure that rates for private passenger vehicle insurance are adequate. To that end, the commission shall adopt rules establishing standards defining inadequate rates on private passenger vehicle insurance as defined in s. 627.041(8). In the event that the office finds that a rate or rate change is inadequate, the office shall order that a new rate or rate schedule be thereafter filed by the insurer and shall further provide information as to the manner in which noncompliance of the standards may be corrected. When a violation of this provision occurs, the office shall impose an administrative fine pursuant to s. 624.4211.

(6) One rate shall be deemed unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the difference in expected losses and expenses.

(7) Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long as rates reflect the differences with reasonable accuracy.

(8) Rates are not unfairly discriminatory if averaged broadly among members of a group; nor are rates unfairly discriminatory even though they are lower than rates for nonmembers of the group. However, such rates are unfairly discriminatory if they are not actuarially measurable and credible and sufficiently related to actual or expected loss and expense experience of the group so as to assure that nonmembers of the group are not unfairly discriminated against. Use of a single United States Postal Service zip code as a rating territory shall be deemed unfairly discriminatory unless filed pursuant to paragraph (1)(a) and the justification for its rate incorporates sufficient actual or expected loss and loss adjustment expense experience so as to be actuarially sound. The office shall require that any rate filing resulting from the use of a single zip code as a rating territory does not contain a rate or rate change that is excessive, inadequate, or unfairly discriminatory.

(9) In reviewing the rate or rate change filed, the office may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated herein.

(10) The office may, at any time, review a rate or rate change, the pertinent records of the insurer, and market conditions; and, if the office finds on a preliminary basis that the rate or rate change may be excessive, inadequate, or unfairly discriminatory, the office shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for a period of 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the office all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer shall not increase the rate until the earlier of 120 days after the date the notification was provided or 180 days after the date of the implementation of the rate. The office may, subject to chapter 120, disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(11) In the event the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule which responds to the findings of the office be filed by the insurer. The office shall further order for any "use and file" filing made in accordance with paragraph (1)(b), that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to such policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding shall be applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(12) Any portion of a judgment entered as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer shall not be included in the insurer's rate base, and shall not be used to justify a rate or rate change. Any portion of a settlement entered as a result of a statutory or common-law bad faith action identified as such and any portion of a settlement wherein an insurer agrees to pay specific punitive damages shall not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages in these judgments and settlements shall not be included in the insurer's rate base and shall not be utilized to justify a rate or rate change.

(13)(a) Underwriting rules not contained in rating manuals shall be filed for private passenger automobile insurance and homeowners insurance.

(b) The submission of rates, rating schedules, and rating manuals to the office by a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this subsection for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the rates, rating schedules, and rating manuals of such organization. All such information shall be available for public inspection, upon receipt by the office, during usual business hours.

(14)(a) Commercial motor vehicle insurance is not subject to subsection (1), subsection (2), or subsection (9) or s. 627.0645.

(b) The rates for insurance described in this subsection may not be excessive, inadequate, or unfairly discriminatory.

(c) Insurers shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on commercial motor vehicle insurance written in this state.

(d) An insurer must notify the office of any changes to rates for type of insurance described in this subsection no later than 30 days after the effective date of the change. The notice shall include the name of the insurer, the type or kind of insurance subject to rate change, and the average statewide percentage change in rates. Actuarial data with regard to rates for risks described in this subsection shall be maintained by the insurer for 2 years after the effective date of changes to those rates and are subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the factors in paragraphs (2)(a)-(l) and apply subsections (3)-(8) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

(e) A rating organization must notify the office of any changes to loss cost for the type of insurance described in this subsection no later than 30 days after the effective date of the change. The notice shall include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to subsection (1), subsection (2), or subsection (9) shall be maintained by the

rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the rate factors in paragraphs (2)(a)-(l) and apply subsections (3)-(8) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

627.066 Excessive profits for motor vehicle insurance prohibited.—
(1) As used herein:
(a) "Private passenger automobile business" means that insurance business that is written on a family automobile policy, standard automobile policy, or personal automobile or similar private passenger automobile policy written for personal use, as opposed to commercial automobile insurance business.
(b) "Cash" means coins, currency, checks, drafts, or money orders.
(2) Each Florida private passenger automobile insurer group shall file with the office, prior to July 1 of each year on forms prescribed by the commission, the following data for Florida private passenger automobile business. The data filed for the group shall be a consolidation of the data of the individual insurers of the group. The data shall include both voluntary and joint underwriting association business, as follows:
(a) Calendar-year total limits earned premium.
(b) Accident-year incurred losses and loss adjustment expenses.
(c) The administrative and selling expenses incurred in this state or allocated to this state for the calendar year.
(d) Policyholder dividends incurred during the applicable calendar year.
(3)(a) Excessive profit has been realized if there has been an underwriting gain for the 3 most recent calendar-accident years combined which is greater than the anticipated underwriting profit plus 5 percent of earned premiums for those calendar-accident years.
(b) As used herein with respect to any 3-year period, "anticipated underwriting profit" means the sum of the dollar amounts obtained by multiplying, for each rate filing of the insurer group in effect during such period, the earned premiums applicable to such rate filing during such period by the percentage factor included in such rate filing for profit and contingencies, such percentage factor having been determined with due recognition to investment income from funds generated by Florida business. Separate calculations need not be made for consecutive rate filings containing the same percentage factor for profits and contingencies.
(4) Each insurer group shall also file a schedule of Florida private passenger automobile loss and loss adjustment experience for each of the 3 most recent accident years. The incurred losses and loss adjustment expenses shall be valued as of March 31 of the year following the close of the accident year, developed to an ultimate basis, and at two 12-month intervals thereafter, each developed to an ultimate basis, so that a total of three evaluations will be provided for each accident year. The first year to be so reported shall be accident year 1976, so that the reporting of 3 accident years will not take place until accident years 1977 and 1978 have become available.
(5) Each insurer group's underwriting gain or loss for each calendar-accident year shall be computed as follows: The sum of the accident-year incurred losses and loss adjustment expenses as of March 31 of the following year, developed to an ultimate basis, plus the administrative and selling expenses incurred in the calendar year, plus policyholder dividends applicable to the calendar year, will be subtracted from the calendar-year earned premium to determine the underwriting gain or loss.
(6) For the 3 most recent calendar-accident years, the underwriting gain or loss will be compared to the anticipated underwriting profit.

(7) If the insurer group has realized an excessive profit, the office shall order a return of the excessive amounts after affording the insurer group an opportunity for hearing and otherwise complying with the requirements of chapter 120. Such excessive amounts shall be refunded in all instances unless the insurer group affirmatively demonstrates to the office that the refund of the excessive amounts will render a member of the insurer group financially impaired or will render it insolvent under the provisions of the Florida Insurance Code.
(8) The excessive amount shall be refunded on a pro rata basis in relation to the final compilation year earned premiums to the voluntary private passenger automobile policyholders of record of the insurer group on December 31 of the final compilation year.
(9) Any excess profit of an insurance company offering motor vehicle insurance shall be returned to policyholders in the form of a cash refund or a credit towards the future purchase of insurance.
(10)(a) Cash refunds to policyholders may be rounded to the nearest dollar.
(b) Data in required reports to the office may be rounded to the nearest dollar.
(c) Rounding, if elected by the insurer group, shall be applied consistently.
(11)(a) Refunds shall be completed in one of the following ways:
1. If the insurer group elects to make a cash refund, the refund shall be completed within 60 days of entry of a final order indicating that excessive profits have been realized.
2. If the insurer group elects to make refunds in the form of a credit to renewal policies, such credits shall be applied to policy renewal premium notices which are forwarded to insureds more than 60 calendar days after entry of a final order indicating that excessive profits have been realized. If an insurer group has made this election but an insured thereafter cancels his or her policy or otherwise allows the policy to terminate, the insurer group shall make a cash refund not later than 60 days after termination of such coverage.
(b) Upon completion of the renewal credits or refund payments, the insurer group shall immediately certify to the office that the refunds have been made.
(12) Any refund or renewal credit made pursuant to this section shall be treated as a policyholder dividend applicable to the year in which it is incurred, for purposes of reporting under this section for subsequent years.

627.915 Insurer experience reporting.—
(1) Each insurer transacting private passenger automobile insurance in this state shall report certain information annually to the office. The information will be due on or before July 1 of each year. The information shall be divided into the following categories: bodily injury liability; property damage liability; uninsured motorist; personal injury protection benefits; medical payments; comprehensive and collision. The information given shall be on direct insurance writings in the state alone and shall represent total limits data. The information set forth in paragraphs (a)-(f) is applicable to voluntary private passenger and Joint Underwriting Association private passenger writings and shall be reported for each of the latest 3 calendar-accident years, with an evaluation date of March 31 of the current year. The information set forth in paragraphs (g)-(j) is applicable to voluntary private passenger writings and shall be reported on a calendar-accident year basis ultimately seven times at seven different stages of development.
(a) Premiums earned for the latest 3 calendar-accident years.
(b) Loss development factors and the historic development of those factors.
(c) Policyholder dividends incurred.
(d) Expenses for other acquisition and general expense.
(e) Expenses for agents' commissions and taxes, licenses, and fees.
(f) Profit and contingency factors as utilized in the insurer's automobile rate filings for the applicable years.
(g) Losses paid.
(h) Losses unpaid.

(i) Loss adjustment expenses paid.
(j) Loss adjustment expenses unpaid.

690-170

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.
(2) The department shall have the powers and authority expressly conferred upon it by, or reasonably implied from, the provisions of this code. The office shall have the powers and authority expressly conferred upon it by, or reasonably implied from, the provisions of this code.
(3) The department or office may conduct such investigations of insurance matters, in addition to investigations expressly authorized, as it may deem proper to determine whether any person has violated any provision of this code within its respective regulatory jurisdiction or to secure information useful in the lawful administration of any such provision. The cost of such investigations shall be borne by the state.
(4) The department and office may each collect, propose, publish, and disseminate information relating to the subject matter of any duties imposed upon it by law.
(5) The department and office shall each have such additional powers and duties as may be provided by other laws of this state.
(6) The department and office may each employ actuaries who shall be at-will employees and who shall serve at the pleasure of the Chief Financial Officer, in the case of department employees, or at the pleasure of the director of the office, in the case of office employees. Actuaries employed pursuant to this paragraph shall be members of the Society of Actuaries or the Casualty Actuarial Society and shall be exempt from the Career Service System established under chapter 110. The salaries of the actuaries employed pursuant to this paragraph shall be set in accordance with [1]s. 216.251(2)(a)5. and shall be set at levels which are commensurate with salary levels paid to actuaries by the insurance industry.
(7) The office, within existing resources, may expend funds for the professional development of its employees, including, but not limited to, professional dues for employees who are required to be members of professional organizations; examinations leading to professional designations required for employment with the office; training courses and examinations provided through, and to ensure compliance with, the National Association of Insurance Commissioners; or other training courses related to the regulation of insurance.
(8) The office shall, within existing resources, develop and implement an outreach program for the purpose of encouraging the entry of additional insurers into the Florida market.
(9) Upon receiving service of legal process issued in any civil action or proceeding in this state against any regulated person or any unauthorized insurer under s. 626.906 or s. 626.937 which is required to appoint the Chief Financial Officer as its attorney to receive service of all legal process, the Chief Financial Officer, as attorney, may, in lieu of sending the process by registered or certified mail, send the process or make it available by any other verifiable means, including, but not limited to, making the documents available by electronic transmission from a secure website established by the department to the person last designated by the regulated person or the unauthorized insurer to receive the process. When process documents are made available electronically, the Chief Financial Officer shall send a notice of receipt of service of process to the person last designated by the regulated person or unauthorized insurer to receive legal process. The notice must state the date and manner in which the copy of the process was made available to the regulated person or unauthorized insurer being served and contain the uniform resource locator (URL) for a hyperlink to access files and information on the department's website to obtain a copy of the process.

(10)(a) The Division of Consumer Services shall perform the following functions concerning products or services regulated by the department or office:
1. Receive inquiries and complaints from consumers.
2. Prepare and disseminate information that the department deems appropriate to inform or assist consumers.
3. Provide direct assistance to and advocacy for consumers who request such assistance or advocacy.
4. With respect to apparent or potential violations of law or applicable rules committed by a person or entity licensed by the department or office, report apparent or potential violations to the office or to the appropriate division of the department, which may take any additional action it deems appropriate.
5. Designate an employee of the division as the primary contact for consumers on issues relating to sinkholes.
(b) Any person licensed or issued a certificate of authority by the department or the office shall respond, in writing, to the division within 20 days after receipt of a written request for information from the division concerning a consumer complaint. The response must address the issues and allegations raised in the complaint. The division may impose an administrative penalty for failure to comply with this paragraph of up to $2,500 per violation upon any entity licensed by the department or the office and $250 for the first violation, $500 for the second violation, and up to $1,000 for the third or subsequent violation upon any individual licensed by the department or the office.
(c) The department may adopt rules to administer this subsection.
(d) The powers, duties, and responsibilities expressed or granted in this subsection do not limit the powers, duties, and responsibilities of the department, the Financial Services Commission, the Office of Insurance Regulation, or the Office of Financial Regulation as otherwise provided by law.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a

computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain:

1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by

authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance

coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.

(f) Number of new policies written.

(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:

1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).

2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.

3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.418 Suspension, revocation of certificate of authority for violations and special grounds.—

(2) The office may, in its discretion, suspend or revoke the certificate of authority of an insurer if it finds that the insurer:

(a) Has violated any lawful order or rule of the office or commission or any provision of this code.

(b) Has refused to be examined or to produce its accounts, records, and files for examination, or if any of its officers have refused to give information with respect to its

affairs or to perform any other legal obligation as to such examination, when required by the office.
(c) Has for any line, class, or combination thereof, with such frequency as to indicate its general business practice in this state, without just cause refused to pay proper claims arising under its policies, whether any such claim is in favor of an insured or is in favor of a third person with respect to the liability of an insured to such third person, or without just cause compels such insureds or claimants to accept less than the amount due them or to employ attorneys or to bring suit against the insurer or such an insured to secure full payment or settlement of such claims.
(d) Is affiliated with and under the same general management or interlocking directorate or ownership as another insurer which transacts direct insurance in this state without having a certificate of authority therefor, except as permitted as to surplus lines insurers under part VIII of chapter 626.
(e) Has been convicted of, or entered a plea of guilty or nolo contendere to, a felony relating to the transaction of insurance, in this state or in any other state, without regard to whether adjudication was withheld.
(f) Has a ratio of net premiums written to surplus as to policyholders that exceeds 4 to 1, and the office has reason to believe that the financial condition of the insurer endangers the interests of the policyholders. The ratio of net premiums written to surplus as to policyholders shall be on an annualized actual or projected basis. The ratio shall be based on the insurer's current calendar year activities and experience to date or the insurer's previous calendar year activities and experience, or both, and shall be calculated to represent a 12-month period. However, the provisions of this paragraph do not apply to any insurance or insurer exempted from s. 624.4095.
(g) Is under suspension or revocation in another state.

624.4211 Administrative fine in lieu of suspension or revocation.—
(1) If the office finds that one or more grounds exist for the discretionary revocation or suspension of a certificate of authority issued under this chapter, the office may, in lieu of such revocation or suspension, impose a fine upon the insurer.
(2) With respect to any nonwillful violation, such fine may not exceed $5,000 per violation. In no event shall such fine exceed an aggregate amount of $20,000 for all nonwillful violations arising out of the same action. If an insurer discovers a nonwillful violation, the insurer shall correct the violation and, if restitution is due, make restitution to all affected persons. Such restitution shall include interest at 12 percent per year from either the date of the violation or the date of inception of the affected person's policy, at the insurer's option. The restitution may be a credit against future premiums due provided that interest accumulates until the premiums are due. If the amount of restitution due to any person is $50 or more and the insurer wishes to credit it against future premiums, it shall notify such person that she or he may receive a check instead of a credit. If the credit is on a policy that is not renewed, the insurer shall pay the restitution to the person to whom it is due.
(3) With respect to any knowing and willful violation of a lawful order or rule of the office or commission or a provision of this code, the office may impose a fine upon the insurer in an amount not to exceed $40,000 for each such violation. In no event shall such fine exceed an aggregate amount of $200,000 for all knowing and willful violations arising out of the same action. In addition to such fines, the insurer shall make restitution when due in accordance with subsection (2).
(4) The failure of an insurer to make restitution when due as required under this section constitutes a willful violation of this code. However, if an insurer in good faith is uncertain as to whether any restitution is due or as to the amount of such restitution, it shall promptly notify the office of the circumstances; and the failure to make restitution pending a determination thereof shall not constitute a violation of this code.

624.604 "Property insurance" defined.—"Property insurance" is insurance on real or personal property of every kind and of every interest therein, whether on land, water, or in the air, against loss or damage from any and all hazard or cause, and against loss consequential upon such loss or damage, other than noncontractual legal liability for any such loss or damage. Property insurance may contain a provision for accidental death or injury as part of a multiple peril homeowner's policy. Such insurance, which is incidental to the property insurance, is not subject to the provisions of this code applicable to life or health insurance. Property insurance does not include title insurance, as defined in s. 624.608.

624.605 "Casualty insurance" defined.—
(1) "Casualty insurance" includes:
(a) Vehicle insurance.—Insurance against loss of or damage to any land vehicle or aircraft or any draft or riding animal, or to property while contained therein or thereon or being loaded or unloaded therein or therefrom, from any hazard or cause, and against any loss, liability, or expense resulting from or incidental to ownership, maintenance, or use of any such vehicle, aircraft, or animal. As to land vehicles, the term also includes insurance providing for medical, hospital, surgical, and disability benefits to injured persons, and funeral and death benefits to dependents, beneficiaries, or personal representatives of persons killed, irrespective of the legal liability of the insured, while in, entering, alighting from, adjusting, repairing, cranking, or being struck by a vehicle, if such insurance is issued as a part of a liability insurance contract.
(b) Liability insurance.—Insurance against legal liability for the death, injury, or disability of any human being, or for damage to property, with provision for medical, hospital, and surgical benefits to the injured persons, irrespective of the legal liability of the insured, when issued as a part of a liability insurance contract.
(c) Workers' compensation and employer's liability.—Insurance of the obligations accepted by, imposed upon, or assumed by employers under law for death, disablement, or injury of employees.
(d) Burglary and theft.—Insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation, or wrongful conversion, disposal, or concealment, or from any attempt at any of the foregoing; including supplemental coverage for medical, hospital, surgical, and funeral expense incurred by the named insured or any other person as a result of bodily injury during the commission of a burglary, robbery, or theft by another; also insurance against loss of or damage to moneys, coins, bullion, securities, notes, drafts, acceptances or any other valuable papers and documents, resulting from any cause.
(e) Personal property floater.—Insurance upon personal effects against loss or damage from any cause under a floater.
(f) Glass.—Insurance against loss or damage to glass, including its lettering, ornamentation, and fittings.
(g) Boiler and machinery.—Insurance against any liability and loss or damage to property or interest resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery, or apparatus, and to make inspection of and issue certificates of inspection upon boilers, machinery, and apparatus of any kind, whether or not insured; together with provision for medical, hospital, and surgical benefits to the injured persons, irrespective of the legal liability of the insured, when issued as an incidental coverage which is part of a liability insurance contract.
(h) Leakage and fire extinguishing equipment.—Insurance against loss or damage to any property or interest caused by the breakage or leakage of sprinklers, hose, pumps, and other fire extinguishing equipment or apparatus, water pipes or containers, or by water

entering through leaks or openings in buildings, and insurance against such loss or damage to such sprinklers, hose, pumps, and other fire extinguishing equipment or apparatus.
(i) Credit.—Insurance against loss or damage resulting from failure of debtors to pay their obligations to the creditor (including loss or damage resulting from the involuntary unemployment of the debtors), except insurance against loss or damage resulting from the death or disability of the debtors. However, insurance may not be written as credit insurance if it falls within the definition of financial guaranty insurance, as defined in s. 627.971.
(j) Credit property insurance.—Credit property insurance is a limited line of insurance providing coverage on personal property used as collateral for securing a loan or on personal property purchased under an installment sales agreement. Credit property insurance shall not be considered to be property insurance. The coverage shall be issued on an inland marine policy form, and coverage limits shall be restricted to the initial amount of the loan or the amount of the installment sale.
(k) Malpractice.—Insurance against legal liability of the insured, and against loss, damage, or expense incidental to a claim of such liability, arising out of the death, injury, or disablement of any person, or arising out of damage to the economic interest of any person, as the result of negligence in rendering expert, fiduciary, or professional service.
(l) Animal.—Insurance against loss or damage to animals, and services of a veterinary for such animals.
(m) Elevator.—Insurance against loss of or damage to any property of the insured resulting from the ownership, maintenance, or use of elevators, except loss or damage by fire, together with provision for medical, hospital, and surgical benefits to injured persons, irrespective of the legal liability of the insured, when issued as an incidental coverage which is part of a liability insurance contract.
(n) Entertainments.—Insurance indemnifying the producer of any motion picture, television, radio, theatrical, sport, spectacle, entertainment, or similar production, event, or exhibition against loss from interruption, postponement, or cancellation thereof due to death, accidental injury, or sickness of performers, participants, directors, or other principals.
(o) Failure of certain institutions to record documents.—Insurance indemnifying banks, bankers, trust companies, and credit unions against loss from failure or omission to record as public records chattel mortgages and liens of every kind upon personal property, given, held, delivered, or possessed as security or collateral for loans, advances, debts, or obligations of all kinds, provided that such insurance does not indemnify intentional omission to comply with the law relating to the recording of liens upon motor vehicles, nor to the intentional omission to record mortgages upon real property.
(p) Failure to file certain personal property instruments.—With respect to persons and institutions other than those referred to in paragraph (o), insurance against loss resulting from failure to file or record written instruments affecting the title of, or creating a lien upon, personal property.
(q) Miscellaneous.—When first approved by the office as not being contrary to law or public policy nor covered by any other kind of insurance as defined in the code, insurance against liability for any other kind of loss or damage to person or property, properly a subject of insurance and not within any other kind of insurance as defined in this code.
(r) Insurance for debt cancellation products.—Insurance that a creditor may purchase against the risk of financial loss from the use of debt cancellation products with consumer loans or leases or retail installment contracts. Insurance for debt cancellation products is not liability insurance but is considered credit insurance only for the purposes of s. 631.52(4).
1. For purposes of this paragraph, the term "debt cancellation products" means loan, lease, or retail installment contract terms, or modifications to loan, lease, or retail installment contracts, under which a creditor agrees to cancel or suspend all or part of a

customer's obligation to make payments upon the occurrence of specified events and includes, but is not limited to, debt cancellation contracts, debt suspension agreements, and guaranteed asset protection contracts. However, the term does not include title insurance as defined in s. 624.608.
2. Debt cancellation products may be offered by financial institutions as defined in s. 655.005, insured depository institutions as defined in 12 U.S.C. s. 1813(c), and subsidiaries of such institutions, as provided in the financial institutions codes; by sellers as defined in s. 721.05, or by the parents, subsidiaries, or affiliated entities of sellers, in connection with the sale of timeshare interests; or by other business entities as specifically authorized by law, and such products are not insurance for purposes of the Florida Insurance Code.
(2) The provision of medical, hospital, surgical, and funeral benefits, and of coverage against accidental death or injury, as part of other insurance as stated under paragraphs (a) (vehicle), (b) (liability), (d) (burglary and theft), (g) (boiler and machinery), or (m) (elevator) of subsection (1) shall for all purposes be deemed to be the same kind of insurance to which it is incidental and shall not be subject to provisions of this code applicable to life or health insurance.

627.021 Scope of this part.—
(1) This part of this chapter applies only to property, casualty, and surety insurances on subjects of insurance resident, located, or to be performed in this state.
(2) This chapter does not apply to:
(a) Reinsurance, except joint reinsurance as provided in s. 627.311.
(b) Insurance against loss of or damage to aircraft, their hulls, accessories, or equipment, or against liability, other than workers' compensation and employer's liability, arising out of the ownership, maintenance, or use of aircraft.
(c) Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine insurance policies.
(d) Commercial inland marine insurance.
(e) Surplus lines insurance placed under the provisions of ss. 626.913-626.937.
(3) For the purposes of this chapter, all motor vehicle insurance shall be deemed to be casualty insurance only.
(4) This part does not apply to health insurance.

627.062 Rate standards.—
(1) The rates for all classes of insurance to which the provisions of this part are applicable may not be excessive, inadequate, or unfairly discriminatory.
(2) As to all such classes of insurance:
(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals that allow the insurer a reasonable rate of return on the classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, must be filed with the office under one of the following procedures:
1. If the filing is made at least 90 days before the proposed effective date and is not implemented during the office's review of the filing and any proceeding and judicial review, such filing is considered a "file and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings does not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be

deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.
2. If the filing is not made in accordance with subparagraph 1., such filing must be made as soon as practicable, but within 30 days after the effective date, and is considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders those portions of rates found to be excessive, as provided in paragraph (h).
3. For all property insurance filings made or submitted after January 25, 2007, but before May 1, 2012, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered property coverages.
(b) Upon receiving a rate filing, the office shall review the filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:
1. Past and prospective loss experience within and without this state.
2. Past and prospective expenses.
3. The degree of competition among insurers for the risk insured.
4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers calculate investment income attributable to classes of insurance written in this state and the manner in which investment income is used to calculate insurance rates. Such manner must contemplate allowances for an underwriting profit factor and full consideration of investment income that produces a reasonable rate of return; however, investment income from invested surplus may not be considered.
5. The reasonableness of the judgment reflected in the filing.
6. Dividends, savings, or unabsorbed premium deposits allowed or returned to policyholders, members, or subscribers in this state.
7. The adequacy of loss reserves.
8. The cost of reinsurance. The office may not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer's estimated 250-year probable maximum loss or any lower level of loss.
9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.
10. Conflagration and catastrophe hazards, if applicable.
11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.
12. Projected flood losses for personal residential property insurance, if applicable, which may be estimated using a model or method, or a straight average of model results or output ranges, independently found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology and as further provided in s. 627.0628.
13. A reasonable margin for underwriting profit and contingencies.
14. The cost of medical services, if applicable.
15. Other relevant factors that affect the frequency or severity of claims or expenses.
(c) In the case of fire insurance rates, consideration must be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.
(d) If conflagration or catastrophe hazards are considered by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that

portion of the premium allocated to such hazard and maintain the premium in a catastrophe reserve. Removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes must be approved by the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes must be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), the office may find a rate to be excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business which is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.

2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, if the replenishment is attributable to investment losses.

3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625.

5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.

6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.

(f) In reviewing a rate filing, the office may require the insurer to provide, at the insurer's expense, all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.

(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being notified, the insurer or rating organization shall, within 60 days, file with the office all information that, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer may not alter the rate except to conform to the office's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of implementing the rate. The office, subject to chapter 120, may disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(h) If the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule, which responds to the findings of the office, be filed by the insurer. The office shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to the policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding is applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.
(i) Except as otherwise specifically provided in this chapter, for property and casualty insurance the office may not directly or indirectly:
1. Prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing; or
2. Impede, abridge, or otherwise compromise an insurer's right to acquire policyholders, advertise, or appoint agents, including the calculation, manner, or amount of such agent commissions, if any.
(j) With respect to residential property insurance rate filings, the rate filing must account for mitigation measures undertaken by policyholders to reduce hurricane losses.
(k)1. A residential property insurer may make a separate filing limited solely to an adjustment of its rates for reinsurance, the cost of financing products used as a replacement for reinsurance, financing costs incurred in the purchase of reinsurance, and the actual cost paid due to the application of the cash build-up factor pursuant to s. 215.555(5)(b) if the insurer:
a. Elects to purchase financing products such as a liquidity instrument or line of credit, in which case the cost included in filing for the liquidity instrument or line of credit may not result in a premium increase exceeding 3 percent for any individual policyholder. All costs contained in the filing may not result in an overall premium increase of more than 15 percent for any individual policyholder.
b. Includes in the filing a copy of all of its reinsurance, liquidity instrument, or line of credit contracts; proof of the billing or payment for the contracts; and the calculation upon which the proposed rate change is based demonstrating that the costs meet the criteria of this section.
2. An insurer that purchases reinsurance or financing products from an affiliated company may make a separate filing only if the costs for such reinsurance or financing products are charged at or below charges made for comparable coverage by nonaffiliated reinsurers or financial entities making such coverage or financing products available in this state.
3. An insurer may make only one filing per 12-month period under this paragraph.
4. An insurer that elects to implement a rate change under this paragraph must file its rate filing with the office at least 45 days before the effective date of the rate change. After an insurer submits a complete filing that meets all of the requirements of this paragraph, the office has 45 days after the date of the filing to review the rate filing and determine if the rate is excessive, inadequate, or unfairly discriminatory.

The provisions of this subsection do not apply to workers' compensation, employer's liability insurance, and motor vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules filed with the office and that have been submitted to the insurer for individual rating, the insurer must maintain documentation on each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason

for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for at least 5 years after the effective date of the policy.

(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.

(c) This subsection does not apply to private passenger motor vehicle insurance.

(d)1. The following categories or kinds of insurance and types of commercial lines risks are not subject to paragraph (2)(a) or paragraph (2)(f):

a. Excess or umbrella.

b. Surety and fidelity.

c. Boiler and machinery and leakage and fire extinguishing equipment.

d. Errors and omissions.

e. Directors and officers, employment practices, fiduciary liability, and management liability.

f. Intellectual property and patent infringement liability.

g. Advertising injury and Internet liability insurance.

h. Property risks rated under a highly protected risks rating plan.

i. General liability.

j. Nonresidential property, except for collateral protection insurance as defined in s. 624.6085.

k. Nonresidential multiperil.

l. Excess property.

m. Burglary and theft.

n. Travel insurance, if issued as a master group policy with a situs in another state where each certificateholder pays less than $30 in premium for each covered trip and where the insurer has written less than $1 million in annual written premiums in the travel insurance product in this state during the most recent calendar year.

o. Medical malpractice for a facility that is not a hospital licensed under chapter 395, a nursing home licensed under part II of chapter 400, or an assisted living facility licensed under part I of chapter 429.

p. Medical malpractice for a health care practitioner who is not a dentist licensed under chapter 466, a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, a pharmacist licensed under chapter 465, or a pharmacy technician registered under chapter 465.

q. Any other commercial lines categories or kinds of insurance or types of commercial lines risks that the office determines should not be subject to paragraph (2)(a) or paragraph (2)(f) because of the existence of a competitive market for such insurance or similarity of such insurance to other categories or kinds of insurance not subject to paragraph (2)(a) or paragraph (2)(f), or to improve the general operational efficiency of the office.

2. Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on insurance and risks described in subparagraph 1. which are written in this state.

3. An insurer shall notify the office of any changes to rates for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the insurer, the type or kind of insurance subject to rate change, and the average statewide percentage change in rates. Actuarial data with regard to rates for such risks must be maintained by the insurer for 2 years after the effective date of changes to those rates and are subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination,

the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b), (c), and (d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

4. A rating organization shall notify the office of any changes to loss cost for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to paragraph (2)(a) or paragraph (2)(f) must be maintained by the rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b)-(d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

(4) The establishment of any rate, rating classification, rating plan or schedule, or variation thereof in violation of part IX of chapter 626 is also in violation of this section.

(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the fund, together with reasonable costs of other reinsurance; however, except as otherwise provided in this section, the insurer may not recoup reinsurance costs that duplicate coverage provided by the fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium, and any over-recoupment must be subtracted from the following year's reimbursement premium.

(6)(a) If an insurer requests an administrative hearing pursuant to s. 120.57 related to a rate filing under this section, the director of the Division of Administrative Hearings shall expedite the hearing and assign an administrative law judge who shall commence the hearing within 30 days after the receipt of the formal request and enter a recommended order within 30 days after the hearing or within 30 days after receipt of the hearing transcript by the administrative law judge, whichever is later. Each party shall have 10 days in which to submit written exceptions to the recommended order. The office shall enter a final order within 30 days after the entry of the recommended order. The provisions of this paragraph may be waived upon stipulation of all parties.

(b) Upon entry of a final order, the insurer may request an expedited appellate review pursuant to the Florida Rules of Appellate Procedure. It is the intent of the Legislature that the First District Court of Appeal grant an insurer's request for an expedited appellate review.

(7) The provisions of this subsection apply only to rates for medical malpractice insurance and control to the extent of any conflict with other provisions of this section.

(a) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base and used to justify a rate or rate change. Any common-law bad faith action identified as such, any portion of a settlement entered as a result of a statutory or common-law action, or any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages may not be included in the insurer's rate base and used to justify a rate or rate change.

(b) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted

and reasonable actuarial techniques, past and present prospective loss experience, using loss experience solely for this state or giving greater credibility to this state's loss data after applying actuarially sound methods of assigning credibility to such data.
(c) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.
(d) The insurer must apply a discount or surcharge based on the health care provider's loss experience or establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used, and provide a copy, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.
(e) For medical malpractice rates subject to paragraph (2)(a), the medical malpractice insurer shall make a rate filing under this section, sworn to by at least two executive officers of the insurer, at least once each calendar year.
(8)(a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a property rate filing subject to paragraph (2)(a):
1. The signing officer and actuary have reviewed the rate filing;
2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading;
3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and
4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.
(b) A signing officer or actuary who knowingly makes a false certification under this subsection commits a violation of s. 626.9541(1)(e) and is subject to the penalties under s. 626.9521.
(c) Failure to provide such certification by the officer and actuary shall result in the rate filing being disapproved without prejudice to be refiled.
(d) The certification made pursuant to paragraph (a) is not rendered false if, after making the subject rate filing, the insurer provides the office with additional or supplementary information pursuant to a formal or informal request from the office. However, the actuary who is primarily responsible for preparing and submitting such information must certify the information in accordance with the certification required under paragraph (a) and the penalties in paragraph (b), except that the chief executive officer, chief financial officer, or chief actuary need not certify the additional or supplementary information.
(e) The commission may adopt rules and forms to administer this subsection.
(9) The burden is on the office to establish that rates are excessive for personal lines residential coverage with a dwelling replacement cost of $1 million or more or for a single condominium unit with a combined dwelling and contents replacement cost of $1 million or more. Upon request of the office, the insurer shall provide such loss and expense information as the office reasonably needs to meet this burden.
(10) Any interest paid pursuant to s. 627.70131(5) may not be included in the insurer's rate base and may not be used to justify a rate or rate change.

627.0629 Residential property insurance; rate filings.—

(1) It is the intent of the Legislature that insurers provide savings to consumers who install or implement windstorm damage mitigation techniques, alterations, or solutions to their properties to prevent windstorm losses. A rate filing for residential property insurance must include actuarially reasonable discounts, credits, or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. The fixtures or construction techniques must include, but are not limited to, fixtures or construction techniques that enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength. Credits, discounts, or other rate differentials, or appropriate reductions in deductibles, for fixtures and construction techniques that meet the minimum requirements of the Florida Building Code must be included in the rate filing. The office shall determine the discounts, credits, other rate differentials, and appropriate reductions in deductibles that reflect the full actuarial value of such revaluation, which may be used by insurers in rate filings.

627.0645 Annual filings.—
(1) Each rating organization filing rates for, and each insurer writing, any line of property or casualty insurance to which this part applies, except:
(a) Workers' compensation and employer's liability insurance;
(b) Insurance as defined in ss. 624.604 and 624.605, limited to coverage of commercial risks other than commercial residential multiperil; or
(c) Travel insurance, if issued as a master group policy with a situs in another state where each certificateholder pays less than $30 in premium for each covered trip and where the insurer has written less than $1 million in annual written premiums in the travel insurance product in this state during the most recent calendar year,

shall make an annual base rate filing for each such line with the office no later than 12 months after its previous base rate filing, demonstrating that its rates are not inadequate.

(2)(a) Deviations filed by an insurer to any rating organization's base rate filing are not subject to this section.
(b) The office, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.
(3) The filing requirements of this section shall be satisfied by one of the following methods:
(a) A rate filing prepared by an actuary which contains documentation demonstrating that the proposed rates are not excessive, inadequate, or unfairly discriminatory pursuant to the applicable rating laws and pursuant to rules of the commission.
(b) If no rate change is proposed, a filing which consists of a certification by an actuary that the existing rate level produces rates which are actuarially sound and which are not inadequate, as defined in s. 627.062.
(4) An insurer may satisfy the annual filing requirements of this section by being a member or subscriber of a licensed rating organization which complies with the requirements of this section.
(5) If an insurer does not employ or otherwise retain the services of an actuary, the insurer's rate filing or certification that rates are actuarially sound shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance

ratemaking. A rate filing or certification prepared by a consultant must be reviewed and signed by an employee of the insurer who is authorized to approve rate filings.
(6) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office no later than the date the filing is due.
(7) Nothing in this section limits the office's authority to review rates at any time or to find that a rate or rate change is excessive, inadequate, or unfairly discriminatory pursuant to s. 627.062.
(8) As used in this section, the term "actuary" means an individual who is a member of the Casualty Actuarial Society.
(9) If an insurer fails to meet the filing requirements of this section and does not submit the filing within 60 days after the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for the line of insurance for which the required filing was not made until such time as the office determines that the required filing is properly submitted.

627.0651 Making and use of rates for motor vehicle insurance.—
(1) Insurers shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on motor vehicle insurance written in this state. A copy of rates, rating schedules, and rating manuals, and changes therein, shall be filed with the office under one of the following procedures:
(a) If the filing is made at least 60 days before the proposed effective date and the filing is not implemented during the office's review of the filing and any proceeding and judicial review, such filing shall be considered a "file and use" filing. In such case, the office shall initiate proceedings to disapprove the rate and so notify the insurer or shall finalize its review within 60 days after receipt of the filing. Notification to the insurer by the office of its preliminary findings shall toll the 60-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue notice to the insurer of its preliminary findings within 60 days after the filing.
(b) If the filing is not made in accordance with the provisions of paragraph (a), such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders portions of rates found to be excessive, as provided in subsection (11).
(2) Upon receiving notice of a rate filing or rate change, the office shall review the rate or rate change to determine if the rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall in accordance with generally accepted and reasonable actuarial techniques consider the following factors:
(a) Past and prospective loss experience within and outside this state.
(b) The past and prospective expenses.
(c) The degree of competition among insurers for the risk insured.
(d) Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. Such investment income shall not include income from invested surplus. The commission may adopt rules utilizing reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to motor vehicle insurance policies written in this state and the manner in which such investment income is used in the calculation of insurance rates. Such manner shall contemplate the use of a positive underwriting profit allowance in the rates that will be compatible with a reasonable rate of return plus

provisions for contingencies. The total of the profit and contingency factor as specified in the filing shall be utilized in computing excess profits in conjunction with s. 627.066. In adopting such rules, the commission shall in all instances adhere to and implement the provisions of this paragraph.
(e) The reasonableness of the judgment reflected in the filing.
(f) Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.
(g) The cost of repairs to motor vehicles.
(h) The cost of medical services, if applicable.
(i) The adequacy of loss reserves.
(j) The cost of reinsurance.
(k) Trend factors, including trends in actual losses per insured unit for the insurer making the filing.
(l) Other relevant factors which impact upon the frequency or severity of claims or upon expenses.
(3) Rates shall be deemed excessive if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.
(4) Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, when such replenishment is attributable to investment losses.
(5)(a) Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.
(b) The office has the responsibility to ensure that rates for private passenger vehicle insurance are adequate. To that end, the commission shall adopt rules establishing standards defining inadequate rates on private passenger vehicle insurance as defined in s. 627.041(8). In the event that the office finds that a rate or rate change is inadequate, the office shall order that a new rate or rate schedule be thereafter filed by the insurer and shall further provide information as to the manner in which noncompliance of the standards may be corrected. When a violation of this provision occurs, the office shall impose an administrative fine pursuant to s. 624.4211.
(6) One rate shall be deemed unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the difference in expected losses and expenses.
(7) Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long as rates reflect the differences with reasonable accuracy.
(8) Rates are not unfairly discriminatory if averaged broadly among members of a group; nor are rates unfairly discriminatory even though they are lower than rates for nonmembers of the group. However, such rates are unfairly discriminatory if they are not actuarially measurable and credible and sufficiently related to actual or expected loss and expense experience of the group so as to assure that nonmembers of the group are not unfairly discriminated against. Use of a single United States Postal Service zip code as a rating territory shall be deemed unfairly discriminatory unless filed pursuant to paragraph (1)(a) and the justification for its rate incorporates sufficient actual or expected loss and loss adjustment expense experience so as to be actuarially sound. The office shall require that any rate filing resulting from the use of a single zip code as a rating territory does not contain a rate or rate change that is excessive, inadequate, or unfairly discriminatory.
(9) In reviewing the rate or rate change filed, the office may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated herein.

(10) The office may, at any time, review a rate or rate change, the pertinent records of the insurer, and market conditions; and, if the office finds on a preliminary basis that the rate or rate change may be excessive, inadequate, or unfairly discriminatory, the office shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for a period of 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the office all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer shall not increase the rate until the earlier of 120 days after the date the notification was provided or 180 days after the date of the implementation of the rate. The office may, subject to chapter 120, disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(11) In the event the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule which responds to the findings of the office be filed by the insurer. The office shall further order for any "use and file" filing made in accordance with paragraph (1)(b), that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to such policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding shall be applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(12) Any portion of a judgment entered as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer shall not be included in the insurer's rate base, and shall not be used to justify a rate or rate change. Any portion of a settlement entered as a result of a statutory or common-law bad faith action identified as such and any portion of a settlement wherein an insurer agrees to pay specific punitive damages shall not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages in these judgments and settlements shall not be included in the insurer's rate base and shall not be utilized to justify a rate or rate change.

(13)(a) Underwriting rules not contained in rating manuals shall be filed for private passenger automobile insurance and homeowners insurance.

(b) The submission of rates, rating schedules, and rating manuals to the office by a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this subsection for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the rates, rating schedules, and rating manuals of such organization. All such information shall be available for public inspection, upon receipt by the office, during usual business hours.

(14)(a) Commercial motor vehicle insurance is not subject to subsection (1), subsection (2), or subsection (9) or s. 627.0645.

(b) The rates for insurance described in this subsection may not be excessive, inadequate, or unfairly discriminatory.

(c) Insurers shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on commercial motor vehicle insurance written in this state.
(d) An insurer must notify the office of any changes to rates for type of insurance described in this subsection no later than 30 days after the effective date of the change. The notice shall include the name of the insurer, the type or kind of insurance subject to rate change, and the average statewide percentage change in rates. Actuarial data with regard to rates for risks described in this subsection shall be maintained by the insurer for 2 years after the effective date of changes to those rates and are subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the factors in paragraphs (2)(a)-(l) and apply subsections (3)-(8) to determine if the rate is excessive, inadequate, or unfairly discriminatory.
(e) A rating organization must notify the office of any changes to loss cost for the type of insurance described in this subsection no later than 30 days after the effective date of the change. The notice shall include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to subsection (1), subsection (2), or subsection (9) shall be maintained by the rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the rate factors in paragraphs (2)(a)-(l) and apply subsections (3)-(8) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

627.221 Rating organizations; licensing; fee.—
(1) A person, whether located within or outside this state, may make application to the office for a license as a rating organization. As to property or inland marine insurance, the application shall be for such kinds of insurance or subdivisions thereof or classes of risk or a part or combination thereof as are specified in the application. As to casualty and surety insurances, the application shall be for such kinds of insurance or subdivisions thereof as are specified in the application. The applicant shall file with its application:
(a) A copy of its constitution, its articles of agreement or association or its certificate of incorporation, and of its bylaws, rules, and regulations governing the conduct of its business;
(b) A list of its members and subscribers;
(c) The name and address of a resident of this state upon whom notices or orders of the office or process affecting such rating organization may be served; and
(d) A statement of its qualifications as a rating organization.

If the office finds that the applicant is competent, trustworthy, and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association or certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business conform to the requirements of law, it shall issue a license specifying (in the case of a casualty or surety rating organization) the kinds of insurance or subdivisions thereof, or (in the case of a property insurance rating organization) the kinds of insurance or subdivisions thereof or classes of risk or a part or combination thereof, for which the applicant is authorized to act as a rating organization.

(2) Licenses issued pursuant to this section shall expire on the September 30 next following date of issuance and shall be subject to annual renewal.
(3) The fee for the license shall be in the amount specified therefor in s. 624.501. This fee, when collected, shall be deposited to the credit of the Insurance Regulatory Trust Fund.

627.301 Advisory organizations.—
(1) No advisory organization shall conduct its operations in this state unless and until it has filed with the office:
(a) A copy of its constitution, articles of incorporation, articles of agreement or of association, and bylaws or rules and regulations governing its activities, all duly certified by the custodian of the originals thereof;
(b) A list of its members and subscribers; and
(c) The name and address of a resident of this state upon whom notices or orders of the office or process may be served.
(2) Every such advisory organization shall notify the office promptly of every change in:
(a) Its constitution;
(b) Its articles of incorporation, agreement, or association;
(c) Its bylaws, rules and regulations governing the conduct of its business;
(d) The list of members and subscribers; and
(e) The name and address of the resident of this state designated by it upon whom notices or orders of the office or process affecting such organization may be served.
(3) No such advisory organization shall engage in any unfair or unreasonable practice with respect to such activities.

690-167

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

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

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other

section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit

committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

627.4143 Outline of coverage.—
(1) No private passenger automobile or basic homeowner policy shall be delivered or issued for delivery in this state unless an appropriate outline of coverage has been delivered prior to issuance of the policy or accompanies the policy when issued.
(2) The outline of coverage for a private passenger motor vehicle insurance policy shall contain all of the following:
(a) A brief description of the principal benefits and coverage provided in the policy, broken down by each class or type of coverage provided under the policy for which a premium is charged, and itemization of the applicable premium.
(b) A summary statement of the principal exclusions and limitations or reductions contained in the policy by class or type, including, but not limited to, deductibles, coinsurance, and any other limitations or reductions.
(c) A summary statement of any renewal or cancellation provisions.
(d) A description of the credit or surcharge plan that is being applied. The description may display numerical or alphabetical codes on the declarations page or premium notice to enable the insured to determine the reason or reasons why her or his policy is being surcharged or is receiving a credit.
(e) A list of any additional coverage provided through any rider or endorsement which accompanies the policy. The list shall contain a descriptive reference to each additional coverage, rather than solely a reference to a form or code number.
(f) The extent of coverage provided to the insured in the event of collision damage to a rental vehicle rented by the insured. The proof-of-insurance card required by s. 316.646 must also specify whether rental car coverage is provided, and may refer to the outline of coverage as to the details or extent of coverage.
(3) A basic homeowner, mobile home owner, dwelling, or condominium unit owner policy may not be delivered or issued for delivery in this state unless a comprehensive checklist of coverage on a form adopted by the commission and an appropriate outline of coverage have been delivered prior to issuance of the policy or accompanies the policy when issued. The commission shall, by rule, adopt a form for the checklist for each type of policy to which this subsection applies. Each form shall indicate that it was adopted by the commission.
(a) The checklist must contain a list of the standard provisions and elements that may typically be included in these policies, whether or not they are included in the particular policy being issued, in a format that allows the insurer to place a check mark next to the provisions elements that are included so that the consumer can see both what is included and what is not included in the policy. As an alternative to checking the boxes on the

checklist, an insurer may delete the check boxes from the form and replace them with text indicating whether the provision's elements are included or not. Limits of liability shall be listed for each item. The checklist must include, but is not limited to, the following:

1. Property coverage for the principal premises shown in the declarations.
2. Property coverage for other structures on the residence premises.
3. Whether the principal premises and other structures are insured against the following perils:

a. Fire.
b. Lightning.
c. Explosion.
d. Hurricane loss.
e. Nonhurricane wind loss.
f. Collapse.
g. Mold.
h. Sinkhole loss.
i. Vandalism.

4. Personal property coverage.
5. Whether personal property is insured against the following perils:

a. Fire.
b. Lightning.
c. Hurricane loss.
d. Nonhurricane wind loss.
e. Collapse.
f. Mold.
g. Sinkhole loss.
h. Theft.

6. The following additional coverages:

a. Debris removal.
b. Loss assessment.
c. Additional living expenses.

7. Personal liability coverage.
8. Medical payments coverage.
9. Discounts applied to the premium.
10. Deductibles for loss due to hurricane and loss to other perils.
11. Building ordinance or law coverage.
12. Replacement cost coverage.
13. Actual cash value coverage.

(b) The forms shall allow insurers to place other coverages on the checklists which may or may not be included in the insurer's policies.

(c) The outline of coverage must contain:

1. A brief description of the principal benefits and coverage provided in the policy, broken down by each class or type of coverage provided under the policy for which a premium is charged, and itemization of the applicable premium.
2. A summary statement of the principal exclusions and limitations or reductions contained in the policy by class or type, including, but not limited to, deductibles, coinsurance, and any other limitations or reductions.
3. A summary statement of any renewal or cancellation provisions.
4. A description of the credit or surcharge plan that is being applied. The description may display numerical or alphabetical codes on the declarations page or premium notice to enable the insured to determine the reason or reasons why her or his policy is being surcharged or is receiving a credit.
5. A summary of any additional coverage provided through any rider or endorsement that accompanies the policy.

(4) The outline of coverage for a private passenger motor vehicle policy is required only on the initial policy issued by an insurer. The outline of coverage and the checklist for a basic homeowner, mobile home owner, dwelling, or condominium unit owner policy is required on the initial policy and each renewal thereof issued by an insurer.
(5) An insurer must insert the following language on the outline of coverage:

"The following outline of coverage or checklist is for informational purposes only. Florida law prohibits this outline or checklist from changing any of the provisions of the insurance contract which is the subject of this outline. Any endorsement regarding changes in types of coverage, exclusions, limitations, reductions, deductibles, coinsurance, renewal provisions, cancellation provisions, surcharges, or credits will be sent separately."

(6) Neither this section nor the outline of coverage or checklist mandated by this section alters or modifies the terms of the insurance contract, creates a cause of action, or is admissible in any civil action.

627.701 Liability of insureds; coinsurance; deductibles.—
(1) A property insurer may issue an insurance policy or contract covering either real or personal property in this state which contains provisions requiring the insured to be liable as a coinsurer with the insurer issuing the policy for any part of the loss or damage by covered peril to the property described in the policy only if:
(a) The following words are printed or stamped on the face of the policy, or a form containing the following words is attached to the policy: "Coinsurance contract: The rate charged in this policy is based upon the use of the coinsurance clause attached to this policy, with the consent of the insured.";
(b) The coinsurance clause in the policy is clearly identifiable; and
(c) The rate for the insurance with or without the coinsurance clause is furnished the insured upon his or her request.
(2) Unless the office determines that the deductible provision is clear and unambiguous, a property insurer may not issue an insurance policy or contract covering real property in this state which contains a deductible provision that:
(a) Applies solely to hurricane losses.
(b) States the deductible as a percentage rather than as a specific amount of money.
(3)(a) Except as otherwise provided in this subsection, prior to issuing a personal lines residential property insurance policy, the insurer must offer alternative deductible amounts applicable to hurricane losses equal to $500, 2 percent, 5 percent, and 10 percent of the policy dwelling limits, unless the specific percentage deductible is less than $500. The written notice of the offer shall specify the hurricane deductible to be applied in the event that the applicant or policyholder fails to affirmatively choose a hurricane deductible. The insurer must provide such policyholder with notice of the availability of the deductible amounts specified in this subsection in a form approved by the office in conjunction with each renewal of the policy. The failure to provide such notice constitutes a violation of this code but does not affect the coverage provided under the policy.
(b) This subsection does not apply with respect to a deductible program lawfully in effect on June 14, 1995, or to any similar deductible program, if the deductible program requires a minimum deductible amount of no less than 2 percent of the policy limits.
(c) With respect to a policy covering a risk with dwelling limits of at least $100,000, but less than $250,000, the insurer may, in lieu of offering a policy with a $500 hurricane deductible as required by paragraph (a), offer a policy that the insurer guarantees it will not nonrenew for reasons of reducing hurricane loss for one renewal period and that contains up to a 2 percent hurricane deductible as required by paragraph (a).

(d) With respect to a policy covering a risk with dwelling limits of $250,000 or more, the insurer need not offer the $500 hurricane deductible as required by paragraph (a), but must, except as otherwise provided in this subsection, offer the other hurricane deductibles as required by paragraph (a).

(4)(a) Any policy that contains a separate hurricane deductible must on its face include in boldfaced type no smaller than 18 points the following statement: "THIS POLICY CONTAINS A SEPARATE DEDUCTIBLE FOR HURRICANE LOSSES, WHICH MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU." A policy containing a coinsurance provision applicable to hurricane losses must on its face include in boldfaced type no smaller than 18 points the following statement: "THIS POLICY CONTAINS A CO-PAY PROVISION THAT MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU."

(b) For any personal lines residential property insurance policy containing a separate hurricane deductible, the insurer shall compute and prominently display the actual dollar value of the hurricane deductible on the declarations page of the policy at issuance and, for renewal, on the renewal declarations page of the policy or on the premium renewal notice.

(c) For any personal lines residential property insurance policy containing an inflation guard rider, the insurer shall compute and prominently display the actual dollar value of the hurricane deductible on the declarations page of the policy at issuance and, for renewal, on the renewal declarations page of the policy or on the premium renewal notice. In addition, for any personal lines residential property insurance policy containing an inflation guard rider, the insurer shall notify the policyholder of the possibility that the hurricane deductible may be higher than indicated when loss occurs due to application of the inflation guard rider. Such notification shall be made on the declarations page of the policy at issuance and, for renewal, on the renewal declarations page of the policy or on the premium renewal notice.

(d)1. A personal lines residential property insurance policy covering a risk valued at less than $500,000 may not have a hurricane deductible in excess of 10 percent of the policy dwelling limits, unless the following conditions are met:

a. The policyholder must personally write and provide to the insurer the following statement in his or her own handwriting and sign his or her name, which must also be signed by every other named insured on the policy, and dated: "I do not want the insurance on my home to pay for the first (specify dollar value) of damage from hurricanes. I will pay those costs. My insurance will not."

b. If the structure insured by the policy is subject to a mortgage or lien, the policyholder must provide the insurer with a written statement from the mortgageholder or lienholder indicating that the mortgageholder or lienholder approves the policyholder electing to have the specified deductible.

2. A deductible subject to the requirements of this paragraph applies for the term of the policy and for each renewal thereafter. Changes to the deductible percentage may be implemented only as of the date of renewal.

3. An insurer shall keep the original copy of the signed statement required by this paragraph, electronically or otherwise, and provide a copy to the policyholder providing the signed statement. A signed statement meeting the requirements of this paragraph creates a presumption that there was an informed, knowing election of coverage.

4. The commission shall adopt rules providing appropriate alternative methods for providing the statements required by this section for policyholders who have a handicapping or disabling condition that prevents them from providing a handwritten statement.

(5)(a) The hurricane deductible of any personal lines residential property insurance policy issued or renewed on or after May 1, 2005, shall be applied as follows:

1. The hurricane deductible shall apply on an annual basis to all covered hurricane losses that occur during the calendar year for losses that are covered under one or more policies issued by the same insurer or an insurer in the same insurer group.

2. If a hurricane deductible applies separately to each of one or more structures insured under a single policy, the requirements of this paragraph apply with respect to the deductible for each structure.
3. If there was a hurricane loss for a prior hurricane or hurricanes during the calendar year, the insurer may apply a deductible to a subsequent hurricane which is the greater of the remaining amount of the hurricane deductible or the amount of the deductible that applies to perils other than a hurricane. Insurers may require policyholders to report hurricane losses that are below the hurricane deductible or to maintain receipts or other records of such hurricane losses in order to apply such losses to subsequent hurricane claims.
4. If there are hurricane losses in a calendar year on more than one policy issued by the same insurer or an insurer in the same insurer group, the hurricane deductible shall be the highest amount stated in any one of the policies. If a policyholder who had a hurricane loss under the prior policy is provided or offered a lower hurricane deductible under the new or renewal policy, the insurer must notify the policyholder, in writing, at the time the lower hurricane deductible is provided or offered, that the lower hurricane deductible will not apply until January 1 of the following calendar year.
(b) For commercial residential property insurance policies issued or renewed on or after January 1, 2006, the insurer must offer the policyholder the following alternative hurricane deductibles:
1. A hurricane deductible that applies on an annual basis as provided in paragraph (a); and
2. A hurricane deductible that applies to each hurricane.
(6)(a) It is the intent of the Legislature to encourage the use of higher hurricane deductibles as a means of increasing the effective capacity of the hurricane insurance market in this state and as a means of limiting the impact of rapidly changing hurricane insurance premiums. The Legislature finds that the hurricane deductibles specified in this subsection are reasonable when a property owner has made adequate provision for restoration of the property to its full value after a catastrophic loss.
(b) A personal lines residential insurance policy providing hurricane coverage may, at the mutual option of the insured and insurer, include a secured hurricane deductible as described in paragraph (c) if the applicant presents the insurer a certificate of security as described in paragraph (d). An insurer may not directly or indirectly require a secured deductible under this subsection as a condition of issuing or renewing a policy. A certificate of security is not required with respect to an applicant who owns a 100 percent equity interest in the property.
(c) A secured hurricane deductible must include the substance of the following:
1. The first $500 of any claim, regardless of the peril causing the loss, is fully deductible.
2. With respect to hurricane losses only, the next $5,000 in losses are fully insured, subject only to a copayment requirement of 10 percent.
3. With respect to hurricane losses only, the remainder of the claim is subject to a deductible equal to a specified percentage of the policy dwelling limits in excess of the deductible allowed under former paragraph (3)(a) but no higher than 10 percent of the policy dwelling limits.
4. The insurer agrees to renew the coverage on a guaranteed basis for a period of years after initial issuance of the secured deductible equal to at least 1 year for each 2 percentage points of deductible specified in subparagraph 3. unless the policy is canceled for nonpayment of premium or the insured fails to maintain the certificate of security. Such renewal shall be at the same premium as the initial policy except for premium changes attributable to changes in the value of the property.
(d) The office shall draft and formally propose as a rule the form for the certificate of security. The certificate of security may be issued in any of the following circumstances:
1. A mortgage lender or other financial institution may issue a certificate of security after granting the applicant a line of credit, secured by equity in real property or other reasonable

security, which line of credit may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss. In the sole discretion of the mortgage lender or other financial institution, the line of credit may be issued to an applicant on an unsecured basis.

2. A licensed insurance agent may issue a certificate of security after obtaining for an applicant a line of credit, secured by equity in real property or other reasonable security, which line of credit may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss. The Florida Hurricane Catastrophe Fund shall negotiate agreements creating a financing consortium to serve as an additional source of lines of credit to secure deductibles. Any licensed insurance agent may act as the agent of such consortium.

3. Any person qualified to act as a trustee for any purpose may issue a certificate of security secured by a pledge of assets, with the restriction that the assets may be drawn on only to pay for the deductible portion of insured construction or reconstruction after a hurricane loss.

4. Any insurer, including any admitted insurer or any surplus lines insurer, may issue a certificate of security after issuing the applicant a policy of supplemental insurance that will pay for 100 percent of the deductible portion of insured construction or reconstruction after a hurricane loss.

5. Any other method approved by the office upon finding that such other method provides a similar level of security as the methods specified in this paragraph and that such other method has no negative impact on residential property insurance catastrophic capacity. The legislative intent of this subparagraph is to provide the flexibility needed to achieve the public policy of expanding property insurance capacity while improving the affordability of property insurance.

(e) An issuer of a certificate of security may terminate the certificate for failure to honor any of the terms of the underlying financial arrangement. The issuer must provide notice of termination to the insurer within 10 working days after termination. Unless the policyholder obtains a replacement certificate of security within an additional 20 working days after such notice, the deductible provision in the policy must revert to a lower deductible otherwise offered by the insurer and the policyholder is responsible for any additional premium required for a policy with such deductible.

(7) Prior to issuing a personal lines residential property insurance policy on or after April 1, 1997, or prior to the first renewal of a residential property insurance policy on or after April 1, 1997, the insurer must offer a deductible equal to $500 applicable to losses from perils other than hurricane. The insurer must provide the policyholder with notice of the availability of the deductible specified in this subsection in a form approved by the office at least once every 3 years. The failure to provide such notice constitutes a violation of this code but does not affect the coverage provided under the policy. An insurer may require a higher deductible only as part of a deductible program lawfully in effect on June 1, 1996, or as part of a similar deductible program.

(8) Notwithstanding the other provisions of this section or of other law, but only as to hurricane coverage as defined in s. 627.4025 for commercial lines residential coverages, an insurer may offer a deductible in an amount not exceeding 10 percent of the insured value if, at the time of such offer and at each renewal, the insurer also offers to the policyholder a deductible in the amount of 3 percent of the insured value. Nothing in this subsection prohibits any deductible otherwise authorized by this section. All forms by which the offers authorized in this subsection are made or required to be made shall be on forms that are adopted or approved by the commission or office.

(9) With respect to hurricane coverage provided in a policy of residential coverage, when the policyholder has taken appropriate hurricane mitigation measures regarding the residence covered under the policy, the insurer shall provide the insured the option of

selecting an appropriate reduction in the policy's hurricane deductible or selecting the appropriate discount credit or other rate differential as provided in s. 627.0629. The insurer must provide the policyholder with notice of the options available under this subsection on a form approved by the office.

69O-207

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

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

624.4211 Administrative fine in lieu of suspension or revocation.—

(2) With respect to any nonwillful violation, such fine may not exceed $5,000 per violation. In no event shall such fine exceed an aggregate amount of $20,000 for all nonwillful violations arising out of the same action. If an insurer discovers a nonwillful violation, the insurer shall correct the violation and, if restitution is due, make restitution to all affected persons. Such restitution shall include interest at 12 percent per year from either the date of the violation or the date of inception of the affected person's policy, at the insurer's option. The restitution may be a credit against future premiums due provided that interest accumulates until the premiums are due. If the amount of restitution due to any person is $50 or more and the insurer wishes to credit it against future premiums, it shall notify such person that she or he may receive a check instead of a credit. If the credit is on a policy that is not renewed, the insurer shall pay the restitution to the person to whom it is due.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the

commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer

to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is

immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.

(f) Number of new policies written.

(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:

1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).

2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.

3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

626.681 Administrative fine in lieu of or in addition to suspension, revocation, or refusal of license, appointment, or disapproval.—

(1) Except as to insurance agencies, if the department finds that one or more grounds exist for the suspension, revocation, or refusal to issue, renew, or continue any license or appointment issued under this chapter, or disapproval of a continuing education course provider, instructor, school official, or monitor groups, the department may, in its discretion, in lieu of or in addition to such suspension or revocation, or in lieu of such refusal, or disapproval, and except on a second offense or when such suspension, revocation, or refusal is mandatory, impose upon the licensee, appointee, course provider, instructor, school official, or monitor group an administrative penalty in an amount up to $500 or, if the department has found willful misconduct or willful violation on the part of the licensee, appointee, course provider, instructor, school official, or monitor group up to $3,500. The administrative penalty may, in the discretion of the department, be augmented by an amount equal to any commissions received by or accruing to the credit of the licensee or appointee in connection with any transaction as to which the grounds for suspension, revocation, or refusal related.

(2) With respect to insurance agencies, if the department finds that one or more grounds exist for the suspension, revocation, or refusal to issue, renew, or continue any license issued under this chapter, the department may, in its discretion, in lieu of or in addition to such suspension or revocation, or in lieu of such refusal, impose upon the licensee an administrative penalty in an amount not to exceed $10,000 per violation. The administrative penalty may, in the discretion of the department, be augmented by an amount equal to any commissions received by or accruing to the credit of the licensee in connection with any transaction as to which the grounds for suspension, revocation, or refusal related.
(3) The department may allow the licensee, appointee, or continuing education course provider, instructor, school official, or monitor group a reasonable period, not to exceed 30 days, within which to pay to the department the amount of the penalty so imposed. If the licensee, appointee, course provider, instructor, school official, or monitor group fails to pay the penalty in its entirety to the department within the period so allowed, the license, appointments, approval, or status of that person shall stand suspended or revoked or issuance, renewal, or continuation shall be refused, as the case may be, upon expiration of such period.

626.894 Administrative fine in lieu of suspension or revocation.—

(2) With respect to any nonwillful violation, such fine may not exceed $1,000 per violation. In no event may such fine exceed an aggregate amount of $5,000 for all nonwillful violations arising out of the same action. When an administrator discovers a nonwillful violation, the administrator shall correct the violation and, if restitution is due, the restitution shall include interest at the rate of 12 percent per year from either the date of the violation or the date of inception of the policy of the affected person, at the option of the administrator. The restitution may be a credit against future premiums due, provided that the interest shall accumulate until the premiums are due. If the amount of restitution due to any person is $50 or more, and the administrator wishes to credit it against future premiums, the administrator shall notify such person that he or she may receive a check instead of a credit. If the credit is on a policy which is not renewed, the administrator shall pay the restitution to the person to whom it is due.

634.021 Powers of department, commission, and office; rules.—The office shall administer this act and the commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this act related to motor vehicle service agreement companies and motor vehicle service agreements. The department shall administer this act and may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this act related to sales representatives.

634.301 Definitions.—As used in this part, the term:
(1) "Gross written premiums" means the total amount of premiums, paid for the entire period of the home warranty, inclusive of commissions, for which the association is obligated under home warranties issued.
(2) "Home warranty" or "warranty" means any contract or agreement whereby a person undertakes to indemnify the warranty holder against the cost of repair or replacement, or actually furnishes repair or replacement, of any structural component or appliance of a home, necessitated by wear and tear or an inherent defect of any such structural component or appliance or necessitated by the failure of an inspection to detect the likelihood of any such loss. However, this part does not prohibit the giving of usual

performance guarantees by either the builder of a home or the manufacturer or seller of an appliance, as long as no identifiable charge is made for such guarantee. This part does not permit the provision of indemnification against consequential damages arising from the failure of any structural component or appliance of a home, which practice constitutes the transaction of insurance subject to all requirements of the insurance code. This part does not apply to service contracts entered into between consumers and nonprofit organizations or cooperatives the members of which consist of condominium associations and condominium owners and which perform repairs and maintenance for appliances or maintenance of the residential property. This part does not apply to a contract or agreement offered by a warranty association in compliance with part III, provided such contract or agreement only relates to the systems and appliances of the covered residential property and does not cover any structural component of the residential property.
(3) "Home warranty association" means any corporation or any other organization, other than an authorized insurer, issuing home warranties.
(4) "Impaired" means having liabilities in excess of assets.
(5) "Insolvent" means the inability of a corporation to pay its debts as they become due in the usual course of its business.
(6) "Insurance code" means the Florida Insurance Code.
(7) "Insurer" means any property or casualty insurer duly authorized to transact such business in this state.
(8) "Listing period" means the period of time residential property is listed for sale with a licensed real estate broker, beginning on the date the residence is first listed for sale and ending on either the date the sale of the residence is closed, the date the residence is taken off the market, or the date the listing contract with the real estate broker expires.
(9) "Net assets" means the amount by which the total statutory assets of an association exceed the total liabilities of the association.
(10) "Person" includes an individual, company, corporation, association, insurer, agent, and every other legal entity.
(11) "Premium" means the total consideration received, or to be received, by an insurer or home warranty association for or related to the issuance and delivery of any binder or warranty, including any charges designated as assessments or fees for policies, surveys, inspections, or service or any other charges.
(12) "Sales representative" means any person with whom an insurer or home inspection or warranty association has a contract and who is utilized by such insurer or association for the purpose of selling or issuing home warranties. The term includes all employees of an insurer or association engaged directly in the sale or issuance of home warranties.
(13) "Structural component" means the roof, plumbing system, electrical system, foundation, basement, walls, ceilings, or floors of a home.

634.402 Powers of department, commission, and office; rules.—The office shall administer this part, and the commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part related to service warranty associations and service warranties. The department shall administer this part and may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this part related to sales representatives. Such rules by the commission or department may identify specific methods of competition or acts or practices that are prohibited by s. 634.436, but shall not enlarge upon or extend the provisions of that section.

634.313 Tax on premiums; annual statement; reports.—

(3) Any association or insurer neglecting to file the annual statement in the form and within the time provided by this section shall forfeit up to $100 for each day during which

such neglect continues; and, upon notice by the office to that effect, its authority to do business in this state shall cease while such default continues. The office shall deposit all sums collected by it under this section to the credit of the Insurance Regulatory Trust Fund.

634.415 Tax on premiums; annual statement; reports.—

(3) The office may levy a fine of up to $100 a day for each day an association neglects to file the annual statement in the form and within the time provided by this part. The amount of the fine shall be established by rules adopted by the commission. The office shall deposit all sums collected by it under this section to the credit of the Insurance Regulatory Trust Fund.

641.26 Annual and quarterly reports.—

(3) Every health maintenance organization shall file quarterly, for the first three calendar quarters of each year, an unaudited financial statement of the organization as described in paragraphs (1)(a) and (b). The statement for the quarter ending March 31 shall be filed on or before May 15, the statement for the quarter ending June 30 shall be filed on or before August 15, and the statement for the quarter ending September 30 shall be filed on or before November 15. The quarterly report shall be verified by the oath of two officers of the organization, properly notarized.

641.36 Adoption of rules; penalty for violation.—The commission shall adopt rules necessary to carry out the provisions of this part. The office shall collect and make available all health maintenance organization rules adopted by the commission. Any violation of a rule adopted under this section shall subject the violating entity to the provisions of s. 641.23.

641.403 Rulemaking authority.—The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part.

641.41 Annual report of prepaid health clinic; administrative penalty.—

(2) Any clinic which neglects to file the annual report in the form and within the time required by this section is subject to an administrative penalty, not to exceed $100 for each day during which the neglect continues; and, upon notice by the office to that effect, the authority of the clinic to do business in this state shall cease while such default continues.

642.0338 Administrative fine in lieu of suspension or revocation.—

(2) With respect to any nonwillful violation, such fine shall not exceed $1,000 per violation. In no event shall such fine exceed an aggregate amount of $5,000 for all nonwillful violations arising out of the same action. When an insurer discovers a nonwillful violation, the insurer shall correct the violation and, if restitution is due, make restitution to all affected persons. Such restitution shall include interest at 12 percent per year from either the date of the violation or the date of inception of the affected person's policy, at the insurer's option. The restitution may be a credit against future premiums due provided that the interest on the restitution will accumulate until the premiums are due. If the amount of restitution due to any person is $50 or more and the insurer wishes to credit it against future premiums, the insurer shall notify such person that it wishes to do so but that the

person may receive a check instead of a credit. If the credit is on a policy which is not renewed, the insurer shall pay the restitution to the person to whom it is due.

651.015 Administration; forms; fees; rules; fines.—The administration of this chapter is vested in the commission, office, and department, which shall:
(1) Prepare and furnish all forms necessary under the provisions of this chapter in relation to applications for provisional certificates of authority, certificates of authority or renewals thereof, statements, examinations, and other required reports. The office is authorized to accept any application statement, report, or information submitted electronically or by facsimile to comply with requirements in this chapter or rules adopted under this section. The commission may adopt rules to implement the provisions of this subsection.
(2) Collect in advance, and the applicant shall pay in advance, the following fees:
(a) At the time of filing an application for a certificate of authority, an application fee in the amount of $75 for each facility.
(b) At the time of filing the annual report required by s. 651.026, a fee in the amount of $100 for each year or part thereof for each facility.
(c) A late fee not to exceed $50 a day for each day of noncompliance.
(d) A fee to cover the actual cost of a credit report and fingerprint processing.
(e) At the time of filing an application for a provisional certificate of authority, a fee in the amount of $50.
(3) Adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter.
(4) Impose administrative fines and penalties pursuant to this chapter.
(5) Deposit all fees and fines collected under the provisions of this chapter into the Insurance Regulatory Trust Fund.

69O-201

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

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of

any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

642.032 Provisions of general insurance law applicable to legal expense insurance corporations.—The following provisions of the Florida Insurance Code shall apply to legal expense insurance corporations, to the extent that they are not inconsistent with the provisions of ss. 642.011-642.049:
(1) Chapter 624, administration and general provisions.
(2) Chapter 625, accounting, investments, and deposits.
(3) Chapter 626, part IX, unfair insurance trade practices.
(4) Chapter 627, part I, rates and rating organizations, and part II, the insurance contract.
(5) Section 628.4615, specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.
(6) Chapter 631, insurer insolvency; guaranty of payment.

69O-200

634.021 Powers of department, commission, and office; rules.—The office shall administer this act and the commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this act related to motor vehicle service agreement companies and motor vehicle service agreements. The department shall administer this act and may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this act related to sales representatives.

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

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

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with

information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.501 Filing, license, appointment, and miscellaneous fees.—The department, commission, or office, as appropriate, shall collect in advance, and persons so served shall pay to it in advance, fees, licenses, and miscellaneous charges as follows:
(1) Certificate of authority of insurer.
(a) Filing application for original certificate of authority or modification thereof as a result of a merger, acquisition, or change of controlling interest due to a sale or exchange of stock, including all documents required to be filed therewith, filing fee.....$1,500.00
(b) Reinstatement fee.....$50.00
(2) Charter documents of insurer.
(a) Filing articles of incorporation or other charter documents, other than at time of application for original certificate of authority, filing fee.....$10.00
(b) Filing amendment to articles of incorporation or charter, other than at time of application for original certificate of authority, filing fee.....$5.00
(c) Filing bylaws, when required, or amendments thereof, filing fee.....$5.00
(3) Annual license tax of insurer, each domestic insurer, foreign insurer, and alien insurer (except that, as to fraternal benefit societies insuring less than 200 members in this state and the members of which as a prerequisite to membership possess a physical handicap or disability, such license tax shall
be $25).....$1,000.00
(4) Statements of insurer, filing (except when filed as part of application for original certificate of authority), filing fees:
(a) Annual statement.....$250.00

(b) Quarterly statement.....$250.00
(5) All insurance representatives, application for license, application for reinstatement of suspended license, each filing, filing fee.....$50.00
(6) Insurance representatives, property, marine, casualty, and surety insurance.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or unaffiliated agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Customer representative's original appointment and biennial renewal or continuation thereof:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(c) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer or unaffiliated agent making an appointment.....$60.00
(d) Service representatives; managing general agents.

Original appointment and biennial renewal or continuation thereof, each insurer or managing general agent, whichever is applicable.....$60.00

(7) Life insurance agents.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or unaffiliated agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer or unaffiliated agent making an appointment.....$60.00
(8) Health insurance agents.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or unaffiliated agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer or unaffiliated agent making an appointment.....$60.00
(9)(a) Except as provided in paragraph (b), all limited appointments as agent, as provided for in s. 626.321. Agent's original appointment and biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) For all limited appointments as agent, as provided in s. 626.321(1)(c) and (d), the agent's original appointment and biennial renewal or continuation thereof for each insurer is equal to the number of offices, branch offices, or places of business covered by the license multiplied by the fees set forth in paragraph (a).
(10) Fraternal benefit society agents. Original appointment and biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(11) Surplus lines agent. Agent's appointment and biennial renewal or continuation thereof, appointment fee.....$150.00
(12) Adjusters:
(a) Adjuster's original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(b) Nonresident adjuster's original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(c) Emergency adjuster's license, appointment fee.....$10.00
(d) Fee to cover actual cost of credit report, when such report must be secured by department.
(13) Examination—Fee to cover actual cost of examination.
(14) Temporary license and appointment as agent or adjuster, where expressly provided for, rate of fee for each month of the period for which the license and appointment is issued.....$5.00

(15) Issuance, reissuance, reinstatement, modification resulting in a modified license being issued, duplicate copy of any insurance representative license, or an appointment being reinstated.....$5.00
(16) Additional appointment continuation fees as prescribed in chapter 626.....$5.00
(17) Filing application for permit to form insurer as referred to in chapter 628, filing fee.....$25.00
(18) Annual license fee of rating organization, each domestic or foreign organization.....$25.00
(19) Miscellaneous services:
(a) For copies of documents or records on file with the department, commission, or office, per
page.....$ .15
(b) For each certificate of the department, commission, or office under its seal, authenticating any document or other instrument (other than a license or certificate of authority).....$5.00
(c) For preparing lists of agents, adjusters, and other insurance representatives, and for other miscellaneous services, such reasonable charge as may be fixed by the office or department.
(d) For processing requests for approval of continuing education courses, processing fee.....$100.00
(e) Insurer's registration fee for agent exchanging business more than 24 times in calendar year under s. 626.752, s. 626.793, or s. 626.837, registration fee per agent per year.....$30.00
(20) Adjusting firm, original or renewal 3-year license.....$60.00
(21) Limited surety agent or professional bail bond agent, as defined in s. 648.25, each agent and each insurer represented. Original appointment and biennial renewal or continuation thereof, each agent or insurer, whichever is applicable:

Appointment fee.....$44.00

State tax.....24.00

County tax.....12.00

Total.....$80.00

(22) Certain military installations, as authorized under s. 626.322: original appointment and biennial renewal or continuation thereof, each insurer.....$20.00
(23) Filing application for original certificate of authority for third-party administrator or original certificate of approval for a service company, including all documents required to be filed therewith, filing fee.....$100.00
(24) Fingerprinting processing fee—Fee to cover fingerprint processing.
(25) Sales representatives, miscellaneous lines. Original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(26) Reinsurance intermediary:
(a) Application filing and license fee.....$50.00
(b) Original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(27) Title insurance agents:
(a) Agent's original appointment or biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Agency original appointment or biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(c) Filing for title insurance agent's license:

Application for filing, each filing, filing fee.....$10.00

(d) Additional appointment continuation fee as prescribed by s. 626.843.....$5.00
(e) Title insurer and title insurance agency administrative surcharge:
1. On or before January 30 of each calendar year, each title insurer shall pay to the office for each licensed title insurance agency appointed by the title insurer and for each retail office of the insurer on January 1 of that calendar year an administrative surcharge of $200.00.
2. On or before January 30 of each calendar year, each licensed title insurance agency shall remit to the department an administrative surcharge of $200.00.

The administrative surcharge may be used solely to defray the costs to the department and office in their examination or audit of title insurance agencies and retail offices of title insurers and to gather title insurance data for statistical purposes to be furnished to and used by the office in its regulation of title insurance.

(28) Late filing of appointment renewals for agents, adjusters, and other insurance representatives, each appointment.....$20.00

634.041 Qualifications for license.—To qualify for and hold a license to issue service agreements in this state, a service agreement company must be in compliance with this part, with applicable rules of the commission, with related sections of the Florida Insurance Code, and with its charter powers and must comply with the following:
(1) Any service agreement company applying for a license must be a solvent corporation formed under the laws of this state or of another state or district of the United States and must meet minimum requirements under this section.
(2) The service agreement company must furnish the office with evidence satisfactory to the office that the management of the company is competent and trustworthy and can successfully and lawfully manage its affairs.
(3) The service agreement company must make the deposit required under s. 634.052.

(4) A service agreement company may not be licensed to transact service agreement business in this state unless it maintains the required reserves and the required ratio of liquid assets to the required reserves.
(5) A service agreement company may not be licensed to transact service agreement business in this state if, during the 3 years immediately preceding its application for a license, it has violated any requirement of this part or a rule adopted thereunder.
(6) In order to obtain or maintain a license, a service agreement company must have and maintain minimum net assets of $500,000. However, a service agreement company that maintains a gross written premium of less than $750,000 at all times, that has been licensed in Florida for more than 5 years, and that has never had an administrative complaint filed by the office against its operations under this part may reach this net asset requirement in equal increments over a 5-year period beginning on October 1, 1991.
(7) All assets used to maintain the minimum net asset requirement must be maintained in the United States.
(8)(a) A service agreement company must establish and maintain an unearned premium reserve in accordance with the following:
1. It must consist of unencumbered assets equal to a minimum of 50 percent of the unearned gross written premium on each service agreement and must amortize this reserve pro rata over the duration of the service agreement. Such assets must be held in the form of cash or invested in securities for investment under ss. 625.301-625.340.
2. In addition to the net asset requirements set forth in subsection (6), a company utilizing the 50-percent reserve must not allow its ratio of gross written premium in force to net assets to exceed 10 to 1. For companies that have utilized both contractual liability insurance and the 50-percent reserve, this ratio must be calculated based only on that portion of gross written premium in force which is covered by the 50-percent reserve.
3. A company that uses an unearned premium reserve must deposit with the department securities of the type eligible for deposit by insurers under s. 625.52 equal to 15 percent of the unearned premium reserve. This reserve deposit may be included as an asset for calculating the requirement of subparagraph 1. A request for release of the reserve deposit may be made quarterly only after the office has approved the company's current quarterly or annual financial statement and a statement sworn to by two officers of the company, verifying that the release will not reduce the reserve deposit to less than 15 percent of the unearned premium reserve.
(b) A service agreement company does not have to establish and maintain an unearned premium reserve if it purchases and maintains contractual liability insurance in accordance with the following:
1. The insurance covers 100 percent of its claim exposure and is obtained from an insurer approved by the office which holds a certificate of authority to do business within this state.
2. If the service agreement company does not meet its contractual obligations, the contractual liability insurance policy binds its issuer to pay or cause to be paid to the service agreement holder all legitimate claims and cancellation refunds for all service agreements issued by the service agreement company while the policy was in effect. This requirement also applies to those service agreements for which no premium has been remitted to the insurer.
3. If the issuer of the contractual liability policy is fulfilling the service agreements covered by the contractual liability policy and the service agreement holder cancels the service agreement, the issuer must make a full refund of unearned premium to the consumer, subject to the cancellation fee provisions of s. 634.121(3). The sales representative and agent must refund to the contractual liability policy issuer their unearned pro rata commission.
4. The policy may not be canceled, terminated, or nonrenewed by the insurer or the service agreement company unless a 90-day written notice thereof has been given to the office by the insurer before the date of the cancellation, termination, or nonrenewal.

5. The service agreement company must provide the office with the claims statistics.

All funds or premiums remitted to an insurer by a motor vehicle service agreement company under this part shall remain in the care, custody, and control of the insurer and shall be counted as an asset of the insurer; provided, however, this requirement does not apply when the insurer and the motor vehicle service agreement company are affiliated companies and members of an insurance holding company system. If the motor vehicle service agreement company chooses to comply with this paragraph but also maintains a reserve to pay claims, such reserve shall only be considered an asset of the covered motor vehicle service agreement company and may not be simultaneously counted as an asset of any other entity.

(9)(a) In meeting the requirements of this part, except as provided in paragraph (b), a service agreement company may not utilize both the 50-percent reserve and contractual liability insurance simultaneously. However, a company may have contractual liability coverage on service agreements previously sold and sell new service agreements covered by the 50-percent reserve, and the converse of this is also allowed. A service agreement company must be able to distinguish how each individual service agreement is covered.
(b) A service agreement company that maintains net assets of at least $10 million and that annually files with the office a financial statement audited in accordance with generally accepted accounting principles may use either the 50-percent reserve or the contractual liability coverage for specific blocks of new service agreements. For purposes of this subsection, the term "specific blocks of new service agreements" means the service agreements sold by a single designated licensed salesperson. A service agreement company must be able to distinguish how each individual service agreement is covered. A service agreement company using the 50-percent premium reserve, as permitted under this subsection, must obtain contractual liability insurance coverage for any future deficits in the premium reserve account directly attributable to the specific blocks of new agreements written. Such a contractual liability insurance policy must be filed with the office. Such policies or endorsements to an existing policy must contain language evidencing that the contractual liability insurance policy shall pay claims arising out of such specific blocks of agreements if the service agreement company cannot or will not pay such claims. All contractual liability insurance policies issued to a service agreement company under this part must cover all agreements issued during the term of the policy and, for purposes of this section, the company must obtain and file with the office endorsements to that policy identifying the specific blocks of agreements not covered thereunder.
(10) In addition to information called for and furnished with its annual statement, a service agreement company must furnish to the office, as soon as reasonably possible, any information as to its transactions or affairs that the office requests in writing. All information furnished pursuant to the request of the office must be verified by the oath of two executive officers of the service agreement company.
(11)(a) A service agreement company offering service agreements providing vehicle protection expenses may meet the requirements for this part only by maintaining contractual liability insurance covering 100 percent of its vehicle protection claim exposure in accordance with paragraph (8)(b), which insurance must be issued by an insurance company not affiliated with the service agreement company, unless the insurance company had issued a contractual liability insurance policy to a service agreement company on or before January 1, 2002. Service agreements providing vehicle protection expenses may be sold only to a service agreement holder that has in-force comprehensive motor vehicle insurance coverage for the vehicle to be covered by the service agreement.
(b) Notwithstanding any other requirement of this part, a service agreement company maintaining an unearned premium reserve on all service agreements in accordance with paragraph (8)(a) may offer service agreements providing vehicle protection expenses if it maintains contractual liability insurance only on all service agreements providing vehicle

protection expenses and continues to maintain the 50-percent reserve for all service agreements not providing vehicle protection expenses. A service agreement company maintaining contractual liability insurance for all service agreements providing vehicle protection expenses and the 50-percent reserve for all other service agreements must, in the service agreement register as required under s. 634.136(2), distinguish between insured service agreements providing vehicle protection expenses and service agreements not providing vehicle protection expenses.
(12) A motor vehicle manufacturer complying with the provisions of this part must be an entity formed under the laws of this state or of another state or district of the United States and need comply only with subsections (2) and (10). A motor vehicle manufacturer need not submit fingerprints, background information, or biographical statements for any individual except those serving as officers or directors of the applicant entity. A motor vehicle manufacturer need not comply with s. 634.081(5). Motor vehicle manufacturers are subject to all other applicable provisions of this part.

634.061 Application for and issuance of license.—
(1) A sworn application for a license as a motor vehicle service agreement company shall be made to and filed with the office on forms as prescribed by the commission and furnished by the office.
(2) In addition to information relative to its qualifications as called for under s. 634.041, the application shall show:
(a) The location of the applicant's home office.
(b) The name and residence address of each director, officer, and 10-percent or greater stockholder of the applicant.
(c) Other pertinent information as required by the commission or office.
(3) The application when filed shall be accompanied by:
(a) If a corporation or partnership, a copy of the applicant's articles of incorporation or partnership document, if any, certified by the public official having custody of the original and a copy of its bylaws certified by its secretary.
(b) A copy of the most recent financial statement of the applicant, verified under the oath of at least two of its principal officers.
(c) The license tax as required under s. 634.071.
(4) Upon completion of the application for license, the office shall examine the same and make such further investigation of the applicant as it deems advisable. If it finds that the applicant is qualified therefor under this part, it shall issue to the applicant a license as a motor vehicle service agreement company. If the office does not so find, it shall refuse to issue the license.

634.071 License continuance.—A license issued under this part shall continue in force as long as the motor vehicle service agreement company is entitled thereto under this part and until suspended, revoked, or terminated. Annually, in conjunction with the March 1 filing of the annual report, each motor vehicle service agreement company shall file a $100 license fee.

634.161 Service of process; method.—
(1) Service of process upon the Chief Financial Officer as process agent of the company shall be made by serving copies in triplicate of the process upon the Chief Financial Officer. Upon receiving such service, the Chief Financial Officer shall file one copy with the department, return one copy with her or his admission of service, and promptly forward one copy of the process by registered or certified mail to the person last designated by the company to receive the same, as provided under s. 634.151.

(2) Process served upon the Chief Financial Officer and copy thereof forwarded as in this section provided shall for all purposes constitute valid and binding service thereof upon the company.

634.252 Acquisition.—Every motor vehicle service agreement company shall be subject to the provisions of s. 628.4615.

642.032 Provisions of general insurance law applicable to legal expense insurance corporations.—The following provisions of the Florida Insurance Code shall apply to legal expense insurance corporations, to the extent that they are not inconsistent with the provisions of ss. 642.011-642.049:
(1) Chapter 624, administration and general provisions.
(2) Chapter 625, accounting, investments, and deposits.
(3) Chapter 626, part IX, unfair insurance trade practices.
(4) Chapter 627, part I, rates and rating organizations, and part II, the insurance contract.
(5) Section 628.4615, specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.
(6) Chapter 631, insurer insolvency; guaranty of payment.

69O-199

634.302 Powers of department, commission, and office; rules.—The office shall administer this part, and the commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part related to home warranty associations and home warranties. The department shall administer this part and may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this part related to sales representatives. Such rules by the commission or department may identify specific methods of competition or acts or practices that are prohibited by s. 634.336 but shall not enlarge upon or extend the provisions of that section.

634.308 Grounds for suspension or revocation of license.—
(1) The license of any home warranty association may be revoked or suspended, or the office may refuse to renew any such license, if it is determined that:
(a) The association has violated any lawful rule or order of the commission or office or any provision of this part.

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

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.

2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with

information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

634.304 Qualifications for license.—The office may not issue or renew a license to any home warranty association unless the association:
(1) Is a solvent corporation formed under the laws of this state or of another state, district, territory, or possession of the United States.
(2) Furnishes the office with evidence satisfactory to it that the management of the association is competent and trustworthy and can successfully manage the affairs of the association in compliance with law.
(3) Proposes to use and uses in its business a name, together with a trademark or emblem, if any, which is distinctive and not so similar to the name or trademark of any other association, corporation, or organization already doing business in this state as will tend to mislead or confuse the public.
(4) Meets the deposit requirements under s. 634.305.
(5) Is otherwise in compliance with this part.

634.306 Application for and issuance of license.—
(1) An application for license as a home warranty association must be made to and must be filed with the office on printed forms prescribed by the commission and furnished by the office.
(2) In addition to information relative to its qualifications as required under s. 634.304, the application must show:
(a) The location of the applicant's home office.

(b) The name and residence address of each director or officer of the applicant and the name and residence address of each shareholder who owns or controls 10 percent or more shares of the applicant.
(c) Such other pertinent information as is required by the office or commission.
(3) The application must be accompanied by:
(a) A copy of the applicant's articles of incorporation, certified by the public official having custody of the original, and a copy of the applicant's bylaws, certified by the applicant's secretary.
(b) A copy of the most recent financial statement of the applicant, verified under oath of at least two of its principal officers.
(c) A license fee in the amount of $200, as required under s. 634.303.
(4) Upon completion of the application for license, the office shall examine the application and make any further investigation of the applicant as it deems advisable. If it finds that the applicant is qualified therefor, the office shall issue to the applicant a license as a home warranty association. If the office does not so find, it shall refuse to issue the license and shall give the applicant written notice of such refusal, setting forth the grounds therefor.

634.307 License expiration; renewal.—Each license as a home warranty association issued under this part shall expire on June 1 next following the date of issuance. If the association is then qualified therefor under the provisions of this part, its license may be renewed annually, upon its request and upon payment to the office of the license tax in the amount of $200, in advance, for each such license year.

634.3073 Acquisition.—Every home warranty association shall be subject to the provisions of s. 628.4615.

634.3077 Financial requirements.—
(1) An association licensed under this part shall maintain a funded, unearned premium reserve account, consisting of unencumbered assets, equal to a minimum of 25 percent of the gross written premiums received by it from all warranty contracts in force. Such assets shall be held in the form of cash or invested in securities for investments as provided in part II of chapter 625.
(2) An association shall maintain, at a minimum, net assets equal to one-sixth of the written premiums it receives for the issuance and delivery of any binder or warranty in force. Net assets may be less than one-sixth of the premiums written provided the association has net assets of not less than $500,000 and maintains a funded, unearned premium reserve account consisting of unencumbered assets equal to a minimum of 40 percent of the gross written premiums received by it from all warranty contracts in force which shall be held in the form of cash or invested in securities for investments as provided in part II of chapter 625.
(3) An association shall not be required to set up an unearned premium reserve if it has purchased contractual liability insurance which demonstrates to the satisfaction of the office that 100 percent of its claim exposure is covered by such insurance. Such contractual liability insurance shall be obtained from an insurer that holds a certificate of authority to do business within the state or from an insurer approved by the office as financially capable of meeting the obligations incurred pursuant to the policy. For purposes of this subsection, the contractual liability policy shall contain the following provisions:
(a) In the event that the home warranty association is unable to fulfill its obligation under its contracts issued in this state for any reason, including insolvency, bankruptcy, or dissolution, the contractual liability insurer will pay losses and unearned premiums under such plans directly to persons making claims under such contracts.

(b) The insurer issuing the policy shall assume full responsibility for the administration of claims in the event of the inability of the association to do so.
(c) The policy may not be canceled or not renewed by either the insurer or the association unless 60 days' written notice thereof has been given to the office by the insurer before the date of such cancellation or nonrenewal.
(d) The contractual liability insurance policy shall insure all home warranty contracts that were issued while the policy was in effect whether or not the premium has been remitted to the insurer.
(4) An association that purchases contractual liability insurance on the warranties that it issues shall provide the office with claim statistics required to be filed by associations not purchasing such insurance.

634.313 Tax on premiums; annual statement; reports.—
(1) In addition to paying the license taxes provided for in this part for home warranty associations and license taxes provided in the insurance code as to insurers, each such association and each such insurer must, annually on or before March 1, file with the office its annual statement, in the form prescribed by the commission, showing all premiums received by it in connection with the issuance of warranties in this state during the preceding calendar year and using accounting principles that will enable the office to ascertain whether the reserve required by s. 634.3077 has been maintained. Each annual statement must contain a balance sheet listing all assets and liabilities; a statement of operations and retained earnings; and a schedule used to report all claims statistics. The annual statement must be completed using generally accepted accounting principles except as otherwise provided in this part. Further, each association and each insurer must pay to the Chief Financial Officer a tax in an amount equal to 2 percent of the amount of such premiums so received.
(2) Premiums received by insurers and taxed under this section are not subject to any premium tax provided for in the insurance code.
(3) Any association or insurer neglecting to file the annual statement in the form and within the time provided by this section shall forfeit up to $100 for each day during which such neglect continues; and, upon notice by the office to that effect, its authority to do business in this state shall cease while such default continues. The office shall deposit all sums collected by it under this section to the credit of the Insurance Regulatory Trust Fund.
(4) The commission may by rule require each home warranty association to submit to the office, as the commission may designate, all or part of the information contained in the financial reports required by this section in a computer-readable form compatible with the electronic data processing system specified by the office.

634.315 Service of process.—Home warranty associations are subject to service of process in the same manner and subject to the same terms, conditions, and fees as apply to insurers under chapter 624.

69O-137

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

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.418 Suspension, revocation of certificate of authority for violations and special grounds.—
(1) The office shall suspend or revoke an insurer's certificate of authority if it finds that the insurer:
(a) Is in unsound financial condition.
(b) Is using such methods and practices in the conduct of its business as to render its further transaction of insurance in this state hazardous or injurious to its policyholders or to the public.
(c) Has failed to pay any final judgment rendered against it in this state within 60 days after the judgment became final.
(d) No longer meets the requirements for the authority originally granted.
(2) The office may, in its discretion, suspend or revoke the certificate of authority of an insurer if it finds that the insurer:
(a) Has violated any lawful order or rule of the office or commission or any provision of this code.
(b) Has refused to be examined or to produce its accounts, records, and files for examination, or if any of its officers have refused to give information with respect to its affairs or to perform any other legal obligation as to such examination, when required by the office.
(c) Has for any line, class, or combination thereof, with such frequency as to indicate its general business practice in this state, without just cause refused to pay proper claims arising under its policies, whether any such claim is in favor of an insured or is in favor of a third person with respect to the liability of an insured to such third person, or without just cause compels such insureds or claimants to accept less than the amount due them or to employ attorneys or to bring suit against the insurer or such an insured to secure full payment or settlement of such claims.
(d) Is affiliated with and under the same general management or interlocking directorate or ownership as another insurer which transacts direct insurance in this state without having a certificate of authority therefor, except as permitted as to surplus lines insurers under part VIII of chapter 626.
(e) Has been convicted of, or entered a plea of guilty or nolo contendere to, a felony relating to the transaction of insurance, in this state or in any other state, without regard to whether adjudication was withheld.
(f) Has a ratio of net premiums written to surplus as to policyholders that exceeds 4 to 1, and the office has reason to believe that the financial condition of the insurer endangers the interests of the policyholders. The ratio of net premiums written to surplus as to policyholders shall be on an annualized actual or projected basis. The ratio shall be based on

the insurer's current calendar year activities and experience to date or the insurer's previous calendar year activities and experience, or both, and shall be calculated to represent a 12-month period. However, the provisions of this paragraph do not apply to any insurance or insurer exempted from s. 624.4095.
(g) Is under suspension or revocation in another state.
(3) The insolvency or impairment of an insurer constitutes an immediate serious danger to the public health, safety, or welfare; and the office may, at its discretion, without prior notice and the opportunity for hearing immediately suspend the certificate of authority of an insurer upon a determination that:
(a) The insurer is impaired or insolvent; or
(b) Receivership, conservatorship, rehabilitation, or other delinquency proceedings have been initiated against the insurer by the public insurance supervisory official of any state.

624.4211 Administrative fine in lieu of suspension or revocation.—
(1) If the office finds that one or more grounds exist for the discretionary revocation or suspension of a certificate of authority issued under this chapter, the office may, in lieu of such revocation or suspension, impose a fine upon the insurer.
(2) With respect to any nonwillful violation, such fine may not exceed $5,000 per violation. In no event shall such fine exceed an aggregate amount of $20,000 for all nonwillful violations arising out of the same action. If an insurer discovers a nonwillful violation, the insurer shall correct the violation and, if restitution is due, make restitution to all affected persons. Such restitution shall include interest at 12 percent per year from either the date of the violation or the date of inception of the affected person's policy, at the insurer's option. The restitution may be a credit against future premiums due provided that interest accumulates until the premiums are due. If the amount of restitution due to any person is $50 or more and the insurer wishes to credit it against future premiums, it shall notify such person that she or he may receive a check instead of a credit. If the credit is on a policy that is not renewed, the insurer shall pay the restitution to the person to whom it is due.
(3) With respect to any knowing and willful violation of a lawful order or rule of the office or commission or a provision of this code, the office may impose a fine upon the insurer in an amount not to exceed $40,000 for each such violation. In no event shall such fine exceed an aggregate amount of $200,000 for all knowing and willful violations arising out of the same action. In addition to such fines, the insurer shall make restitution when due in accordance with subsection (2).
(4) The failure of an insurer to make restitution when due as required under this section constitutes a willful violation of this code. However, if an insurer in good faith is uncertain as to whether any restitution is due or as to the amount of such restitution, it shall promptly notify the office of the circumstances; and the failure to make restitution pending a determination thereof shall not constitute a violation of this code.

624.424 Annual statement and other information.—

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

627.331 Recording and reporting of loss, expense, and claims experience; rating information.—

627.331 Recording and reporting of loss, expense, and claims experience; rating information.—
(1) The commission may promulgate rules and statistical plans which shall thereafter be used by each insurer in the recording and reporting of its loss, expense, and claims experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the office in determining whether the insurer's activities comply with the applicable standards of this code.
(2) In promulgating such rules and plans, the commission shall give due consideration to the rating systems in use in this state and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system used by it, except for motor vehicle insurance as otherwise provided by law.
(3) The office may designate one or more rating organizations or other agencies to assist it in gathering such experience and making compilations thereof; and such compilations shall be made available, subject to reasonable rules adopted by the commission, to insurers and rating organizations.

627.062 Rate standards.—
(1) The rates for all classes of insurance to which the provisions of this part are applicable may not be excessive, inadequate, or unfairly discriminatory.
(2) As to all such classes of insurance:
(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals that allow the insurer a reasonable rate of return on the classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, must be filed with the office under one of the following procedures:
1. If the filing is made at least 90 days before the proposed effective date and is not implemented during the office's review of the filing and any proceeding and judicial review, such filing is considered a "file and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings does not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.
2. If the filing is not made in accordance with subparagraph 1., such filing must be made as soon as practicable, but within 30 days after the effective date, and is considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders those portions of rates found to be excessive, as provided in paragraph (h).
3. For all property insurance filings made or submitted after January 25, 2007, but before May 1, 2012, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered property coverages.
(b) Upon receiving a rate filing, the office shall review the filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:
1. Past and prospective loss experience within and without this state.

2. Past and prospective expenses.
3. The degree of competition among insurers for the risk insured.
4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers calculate investment income attributable to classes of insurance written in this state and the manner in which investment income is used to calculate insurance rates. Such manner must contemplate allowances for an underwriting profit factor and full consideration of investment income that produces a reasonable rate of return; however, investment income from invested surplus may not be considered.
5. The reasonableness of the judgment reflected in the filing.
6. Dividends, savings, or unabsorbed premium deposits allowed or returned to policyholders, members, or subscribers in this state.
7. The adequacy of loss reserves.
8. The cost of reinsurance. The office may not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer's estimated 250-year probable maximum loss or any lower level of loss.
9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.
10. Conflagration and catastrophe hazards, if applicable.
11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.
12. Projected flood losses for personal residential property insurance, if applicable, which may be estimated using a model or method, or a straight average of model results or output ranges, independently found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology and as further provided in s. 627.0628.
13. A reasonable margin for underwriting profit and contingencies.
14. The cost of medical services, if applicable.
15. Other relevant factors that affect the frequency or severity of claims or expenses.

(c) In the case of fire insurance rates, consideration must be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.

(d) If conflagration or catastrophe hazards are considered by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and maintain the premium in a catastrophe reserve. Removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes must be approved by the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes must be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), the office may find a rate to be excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business which is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.
2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, if the replenishment is attributable to investment losses.

3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.
4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625.
5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.
6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.
(f) In reviewing a rate filing, the office may require the insurer to provide, at the insurer's expense, all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.
(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being notified, the insurer or rating organization shall, within 60 days, file with the office all information that, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer may not alter the rate except to conform to the office's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of implementing the rate. The office, subject to chapter 120, may disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.
(h) If the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule, which responds to the findings of the office, be filed by the insurer. The office shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to the policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding is applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.
(i) Except as otherwise specifically provided in this chapter, for property and casualty insurance the office may not directly or indirectly:
1. Prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing; or

2. Impede, abridge, or otherwise compromise an insurer's right to acquire policyholders, advertise, or appoint agents, including the calculation, manner, or amount of such agent commissions, if any.
(j) With respect to residential property insurance rate filings, the rate filing must account for mitigation measures undertaken by policyholders to reduce hurricane losses.
(k)1. A residential property insurer may make a separate filing limited solely to an adjustment of its rates for reinsurance, the cost of financing products used as a replacement for reinsurance, financing costs incurred in the purchase of reinsurance, and the actual cost paid due to the application of the cash build-up factor pursuant to s. 215.555(5)(b) if the insurer:
a. Elects to purchase financing products such as a liquidity instrument or line of credit, in which case the cost included in filing for the liquidity instrument or line of credit may not result in a premium increase exceeding 3 percent for any individual policyholder. All costs contained in the filing may not result in an overall premium increase of more than 15 percent for any individual policyholder.
b. Includes in the filing a copy of all of its reinsurance, liquidity instrument, or line of credit contracts; proof of the billing or payment for the contracts; and the calculation upon which the proposed rate change is based demonstrating that the costs meet the criteria of this section.
2. An insurer that purchases reinsurance or financing products from an affiliated company may make a separate filing only if the costs for such reinsurance or financing products are charged at or below charges made for comparable coverage by nonaffiliated reinsurers or financial entities making such coverage or financing products available in this state.
3. An insurer may make only one filing per 12-month period under this paragraph.
4. An insurer that elects to implement a rate change under this paragraph must file its rate filing with the office at least 45 days before the effective date of the rate change. After an insurer submits a complete filing that meets all of the requirements of this paragraph, the office has 45 days after the date of the filing to review the rate filing and determine if the rate is excessive, inadequate, or unfairly discriminatory.

The provisions of this subsection do not apply to workers' compensation, employer's liability insurance, and motor vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules filed with the office and that have been submitted to the insurer for individual rating, the insurer must maintain documentation on each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for at least 5 years after the effective date of the policy.
(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.
(c) This subsection does not apply to private passenger motor vehicle insurance.
(d)1. The following categories or kinds of insurance and types of commercial lines risks are not subject to paragraph (2)(a) or paragraph (2)(f):
a. Excess or umbrella.
b. Surety and fidelity.
c. Boiler and machinery and leakage and fire extinguishing equipment.
d. Errors and omissions.

e. Directors and officers, employment practices, fiduciary liability, and management liability.
f. Intellectual property and patent infringement liability.
g. Advertising injury and Internet liability insurance.
h. Property risks rated under a highly protected risks rating plan.
i. General liability.
j. Nonresidential property, except for collateral protection insurance as defined in s. 624.6085.
k. Nonresidential multiperil.
l. Excess property.
m. Burglary and theft.
n. Travel insurance, if issued as a master group policy with a situs in another state where each certificateholder pays less than $30 in premium for each covered trip and where the insurer has written less than $1 million in annual written premiums in the travel insurance product in this state during the most recent calendar year.
o. Medical malpractice for a facility that is not a hospital licensed under chapter 395, a nursing home licensed under part II of chapter 400, or an assisted living facility licensed under part I of chapter 429.
p. Medical malpractice for a health care practitioner who is not a dentist licensed under chapter 466, a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, a pharmacist licensed under chapter 465, or a pharmacy technician registered under chapter 465.
q. Any other commercial lines categories or kinds of insurance or types of commercial lines risks that the office determines should not be subject to paragraph (2)(a) or paragraph (2)(f) because of the existence of a competitive market for such insurance or similarity of such insurance to other categories or kinds of insurance not subject to paragraph (2)(a) or paragraph (2)(f), or to improve the general operational efficiency of the office.
2. Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on insurance and risks described in subparagraph 1. which are written in this state.
3. An insurer shall notify the office of any changes to rates for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the insurer, the type or kind of insurance subject to rate change, and the average statewide percentage change in rates. Actuarial data with regard to rates for such risks must be maintained by the insurer for 2 years after the effective date of changes to those rates and are subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b), (c), and (d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.
4. A rating organization shall notify the office of any changes to loss cost for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to paragraph (2)(a) or paragraph (2)(f) must be maintained by the rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b)-(d) and

the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.
(4) The establishment of any rate, rating classification, rating plan or schedule, or variation thereof in violation of part IX of chapter 626 is also in violation of this section.
(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the fund, together with reasonable costs of other reinsurance; however, except as otherwise provided in this section, the insurer may not recoup reinsurance costs that duplicate coverage provided by the fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium, and any over-recoupment must be subtracted from the following year's reimbursement premium.
(6)(a) If an insurer requests an administrative hearing pursuant to s. 120.57 related to a rate filing under this section, the director of the Division of Administrative Hearings shall expedite the hearing and assign an administrative law judge who shall commence the hearing within 30 days after the receipt of the formal request and enter a recommended order within 30 days after the hearing or within 30 days after receipt of the hearing transcript by the administrative law judge, whichever is later. Each party shall have 10 days in which to submit written exceptions to the recommended order. The office shall enter a final order within 30 days after the entry of the recommended order. The provisions of this paragraph may be waived upon stipulation of all parties.
(b) Upon entry of a final order, the insurer may request an expedited appellate review pursuant to the Florida Rules of Appellate Procedure. It is the intent of the Legislature that the First District Court of Appeal grant an insurer's request for an expedited appellate review.
(7) The provisions of this subsection apply only to rates for medical malpractice insurance and control to the extent of any conflict with other provisions of this section.
(a) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base and used to justify a rate or rate change. Any common-law bad faith action identified as such, any portion of a settlement entered as a result of a statutory or common-law action, or any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages may not be included in the insurer's rate base and used to justify a rate or rate change.
(b) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, using loss experience solely for this state or giving greater credibility to this state's loss data after applying actuarially sound methods of assigning credibility to such data.
(c) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.
(d) The insurer must apply a discount or surcharge based on the health care provider's loss experience or establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used, and provide a copy, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.

(e) For medical malpractice rates subject to paragraph (2)(a), the medical malpractice insurer shall make a rate filing under this section, sworn to by at least two executive officers of the insurer, at least once each calendar year.
(8)(a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a property rate filing subject to paragraph (2)(a):
1. The signing officer and actuary have reviewed the rate filing;
2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading;
3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and
4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.
(b) A signing officer or actuary who knowingly makes a false certification under this subsection commits a violation of s. 626.9541(1)(e) and is subject to the penalties under s. 626.9521.
(c) Failure to provide such certification by the officer and actuary shall result in the rate filing being disapproved without prejudice to be refiled.
(d) The certification made pursuant to paragraph (a) is not rendered false if, after making the subject rate filing, the insurer provides the office with additional or supplementary information pursuant to a formal or informal request from the office. However, the actuary who is primarily responsible for preparing and submitting such information must certify the information in accordance with the certification required under paragraph (a) and the penalties in paragraph (b), except that the chief executive officer, chief financial officer, or chief actuary need not certify the additional or supplementary information.
(e) The commission may adopt rules and forms to administer this subsection.
(9) The burden is on the office to establish that rates are excessive for personal lines residential coverage with a dwelling replacement cost of $1 million or more or for a single condominium unit with a combined dwelling and contents replacement cost of $1 million or more. Upon request of the office, the insurer shall provide such loss and expense information as the office reasonably needs to meet this burden.
(10) Any interest paid pursuant to s. 627.70131(5) may not be included in the insurer's rate base and may not be used to justify a rate or rate change.

627.171 Excess rates.—
(1) With written consent of the insured signed prior to the policy inception date and filed with the insurer, the insurer may use a rate in excess of the otherwise applicable filed rate on any specific risk. The signed consent form must include the filed rate as well as the excess rate for the risk insured, and a copy of the form must be maintained by the insurer for 3 years and be available for review by the office.
(2) An insurer may not use excess rates pursuant to this section for more than 10 percent of its commercial insurance policies written or renewed in each calendar year for any line of commercial insurance or for more than 5 percent of its personal lines insurance policies written or renewed in each calendar year for any line of personal insurance. In determining the 10-percent limitation for commercial insurance policies, the insurer shall exclude any workers' compensation policy that was written for an employer who had coverage in the

joint underwriting plan created by s. 627.311(5) immediately prior to the writing of the policy by the insurer and any workers' compensation policy that was written for an employer who had been offered coverage in the joint underwriting plan but who was written a policy by the insurer in lieu of accepting the joint underwriting plan policy. These workers' compensation policies shall be excluded from the 10-percent limitation for the first 3 years of coverage.

690-202

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

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

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of

any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

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

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

627.481 Requirements for certain annuity agreements.—
(1) Any duly organized domestic or foreign nonstock corporation, or any unincorporated charitable trust, if such corporation or trust:
(a) Has been in active operation for at least 5 years prior thereto and has qualified as an exempt organization under the Internal Revenue Code, 26 U.S.C. s. 501(c)(3), or
(b) Has been wholly controlled for at least 10 years by a corporation or trust qualified under paragraph (a), if the subunit has been a corporation or trust for at least 2 years, and has engaged in the selling of annuity agreements authorized under this section in at least three other states without complaint,

may enter into annuity agreements with donors in accordance with this section. Such corporation or trust may receive gifts conditioned upon, or in return for, its agreement to pay an annuity to the donor or other designated beneficiary or beneficiaries and to make and carry out such annuity agreement. Annuity benefits under any such annuity agreement must be calculated to return to such corporation or trust upon the death of the annuitant a residue at least equal to one-half the original gift or other consideration for such annuity.

(2)(a) Every such domestic corporation or such domestic or foreign trust shall have and maintain admitted assets at least equal to the sum of the reserves on its outstanding annuity agreements, and a surplus of 10 percent of such reserves, calculated using:
1.a. The present value of future guaranteed benefits for individual annuities that have either commenced paying benefits or have fixed a future date of the first benefit payment.
b. The commissioner's annuity reserve method, as set forth in s. 625.121(7)(c), for individual deferred annuities that have not fixed a date for the first benefit payment.
2. The mortality tables used to value individual annuities, as defined in s. 625.121(5).
a. For annuities issued prior to July 1, 1998:
(I) The mortality tables described in s. 625.121(5)(h), for individual annuities;
(II) At the option of the corporation or trust, the 1983 Individual Annuity Mortality Table; or
(III) At the option of the corporation or trust, the 2000 Individual Annuity Mortality Table for annuities issued between January 1, 1998, and June 30, 1998, inclusive.
b. For annuities issued on or after July 1, 1998:

(I) The mortality tables set forth in s. 625.121(5)(i)3.;
(II) Any other mortality tables required to be used by insurers in accordance with s. 625.121; or
(III) At the option of the corporation or trust, any other mortality tables authorized to be used by insurers in accordance with s. 625.121.
3. An interest rate not greater than the maximum interest rate permitted for the valuation of individual annuities issued during the same calendar year as the charitable gift annuity for individual annuities as set forth in s. 625.121(6)(b)-(f).
a. The maximum statutory valuation interest rates for single-premium immediate annuities for 1992 may be used for annuities issued in 1992 or any prior year. The maximum statutory valuation interest rates for single-premium immediate annuities issued in 1992 through 2001 are as follows:

Year of Issue	Single Premium Immediate Annuity Interest Rate
1992	7.75 percent
1993	7.00 percent
1994	6.50 percent
1995	7.25 percent
1996	6.75 percent
1997	6.75 percent
1998	6.25 percent
1999	6.25 percent
2000	7.00 percent
2001	6.75 percent

b. For 2002 and subsequent years, until an interest rate for a specified year can be determined in accordance with s. 625.121(6), the prior year's rate shall be used unless the office requires use of a lower rate.
(b) In determining the reserves of any such corporation or trust, a deduction shall be made for all or any portion of an annuity risk which is reinsured by a life insurance company authorized to do business in this state.
(c)1. The assets of such corporation or trust in an amount at least equal to the sum of such reserves and surplus shall be invested only in mutual funds or investments permitted under part II of chapter 625 for the investment of the reserves of authorized life insurance companies.
2. For purposes of this section, the provisions of s. 625.305(2)(a) shall not apply. In lieu thereof, the fair market value of investments made by such corporation or trust in stock authorized by s. 625.324 may not exceed 50 percent of such corporation's or trust's required reserves and surplus. The fair market value in stock of any one corporation or mutual fund may not exceed 10 percent of such corporation's or trust's required reserves and surplus. All other provisions of s. 625.305 shall apply. Such assets shall be segregated as separate and distinct funds, independent of all other funds of such corporation or trust, and shall not be applied for the payment of the debts and obligations of the corporation or trust or for any purpose other than the annuity benefits specified in this section.
(3) No such foreign corporation shall make these annuity agreements in this state unless it complies with all the requirements of this section imposed upon like domestic corporations, except that the corporation may invest its reserve and surplus funds in the kind of securities permitted by the laws of the state in which it was incorporated or organized.
(4) Any corporation or trust that engages in the business of issuing these annuity agreements shall notify the office in writing by the later of 90 days after the effective date

of this act or the date on which it enters into the first of these annuity agreements. The notice must:
(a) Be signed by two or more officers or directors of the organization;
(b) Identify the organization; and
(c) Certify that the organization meets the requirements of this section.
(5) Any annuity agreement entered into by a corporation or trust must contain the following clause: "This annuity is not issued by an insurance company, is subject only to limited regulation by the State of Florida and is not protected or otherwise guaranteed by any government agency."
(6) If the office finds that any such corporation or trust has failed to comply with the requirements of this section, it may order such corporation or trust to cease making any new annuity agreements until such requirements have been satisfied. The office may, in its discretion, require annual statements by such corporation or trust and may accept in lieu thereof a sworn statement by two or more of the principal officers thereof, in such form as will satisfy the office that the requirements of this section are being complied with.
(7) Except as provided in this section, every such corporation or trust shall be exempt from the provisions of this code in making annuity agreements issued under this section.
(8) Any annuity agreement entered into by a corporation or trust the sole purpose of which is to support a state institution of higher learning shall contain the following clause:

"This agreement is the entire contract between the parties, with rights and responsibilities of each party to the other as set forth herein. The donor or annuitant shall not have recourse against any assets of the state other than any funds or assets donated by, or funds derived from any assets donated by, the donor as set forth herein."

(9) Agreements in the form of a charitable remainder unitrust trust, charitable remainder annuity trust, charitable lead trust, pooled income fund or other similar charitable split interest trust arrangement (not including a charitable gift annuity), described in ss. 170(f)(2)(A) and (B), 664(d)(1) and (2), and 642(c)(5) of the Internal Revenue Code are exempt from the provisions of subsections (1), (2), (3), and (5).
(10) The provisions of part IX of chapter 626 apply to issuers of annuity agreements under this section.
(11) The commission shall adopt rules and forms for the filing of annual statements and agreements pertaining to donor annuity organizations.

69O-194

641.403 Rulemaking authority.—The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the

accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.501 Filing, license, appointment, and miscellaneous fees.—

(26) Reinsurance intermediary:
(a) Application filing and license fee.....$50.00
(b) Original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00

641.402 Definitions.—As used in this part, the term:
(1) "Basic services" includes any of the following: emergency care, physician care other than hospital inpatient physician services, ambulatory diagnostic treatment, and preventive health care services.
(2) "Guaranteeing organization" means an organization that is domiciled in the United States; that has authorized service of process against it; and that has appointed the Chief Financial Officer as its agent for service of process in connection with any cause of action arising in this state, based upon any guarantee entered into under this part.
(3) "Insolvent" or "insolvency" means the inability of a prepaid health clinic to discharge its liabilities as they become due in the normal course of business.
(4) "Prepaid health clinic" means any organization authorized under this part which provides, either directly or through arrangements with other persons, basic services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis, including those basic services which subscribers might reasonably require to maintain good health. However, no clinic that provides or contracts for, either directly or indirectly, inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services shall be a prepaid health clinic.
(5) "Prepaid health clinic contract" means any contract entered into by a prepaid health clinic with a subscriber or group of subscribers to provide any of the basic services in exchange for a prepaid per capita or prepaid aggregate fixed sum.
(6) "Provider" means any physician or person other than a hospital that furnishes health care services and is licensed or authorized to practice in this state.
(7) "Reporting period" means the particular span of time by or for which accounts are redeemed on an annualized basis.
(8) "Subscriber" means an individual who has contracted, or on whose behalf a contract has been entered into, with a prepaid health clinic for health care services.
(9) "Surplus" means total unencumbered assets in excess of total liabilities. Surplus includes capital stock, capital in excess of par, and retained earnings and may include surplus notes.
(10) "Surplus notes" means debt that has been guaranteed by the United States Government or its agencies or debt that has been subordinated to all claims of subscribers and general creditors of the prepaid health clinic.

641.405 Application for certificate of authority to operate prepaid health clinic.—
(1) No person may operate a prepaid health clinic without first obtaining a certificate of authority from the office. The office shall not issue a certificate of authority to any applicant which does not possess a valid Health Care Provider Certificate issued by the Agency for Health Care Administration.
(2) Each application for a certificate of authority shall be on such form as the commission prescribes, and such application shall be accompanied by:
(a) A copy of the basic organizational document of the applicant, if any, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable document, and all amendments to such document.
(b) A copy of the constitution, bylaws, rules and regulations, or similar form of document, if any, regulating the conduct of the affairs of the applicant.
(c) A list of the names, addresses, and official capacities with the applicant of the persons who are to be responsible for the conduct of the affairs of the clinic, including all members of the governing body, the officers and directors in the case of a corporation, and the partners or associates in the case of a partnership or association. Such persons shall fully disclose to the office and the governing body of the clinic the extent and nature of any contracts or arrangements between them and the clinic, including any possible conflicts of interest.
(d) A statement generally describing the clinic and its operations.
(e) Each form of prepaid health clinic contract that the applicant proposes to offer the subscribers, showing for each form of contract the benefits to which the subscribers are entitled, together with a table of the rates charged, or proposed to be charged.
(f) A copy of the applicant's Health Care Provider Certificate from the Agency for Health Care Administration, issued pursuant to part III of this chapter.
(g) A financial statement prepared on the basis of generally accepted accounting principles, except that surplus notes acceptable to the office may be included in the calculation of surplus.

641.41 Annual report of prepaid health clinic; administrative penalty.—
(1) Each prepaid health clinic shall file a report with the office, annually on or before March 1, or within 3 months of the end of the reporting period of the clinic, or within such extension of time for the filing of the report as the office, for good cause, may grant. The report of the prepaid health clinic must be filed on forms prescribed by the commission and must be verified under oath by two executive officers of the clinic or, if the clinic is not a corporation, verified under oath by two persons who are principal managing directors of the affairs of the clinic. The report of the clinic shall show the condition of the clinic on the last day of the immediately preceding reporting period. Such report shall include:
(a) A financial statement of the clinic, including its balance sheet and a statement of operations for the preceding year;
(b) A list of the name and residence address of every person responsible for the conduct of the affairs of the clinic, together with a disclosure of the extent and nature of any contract or arrangement between such person and the clinic, including any possible conflicts of interest;
(c) The number of prepaid health clinic contracts issued and outstanding, and the number of prepaid health clinic contracts terminated and a compilation of the reasons for such terminations;
(d) Such statistical information as is requested by the commission or office, which information shows the rates of the clinic for all basic services provided under prepaid health clinic contracts;
(e) The number and amount of damage claims for medical injury initiated against the clinic and any of the providers engaged by it during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim; and

(f) Such other information relating to the performance of the clinic as is required by the commission or office.
(2) Any clinic which neglects to file the annual report in the form and within the time required by this section is subject to an administrative penalty, not to exceed $100 for each day during which the neglect continues; and, upon notice by the office to that effect, the authority of the clinic to do business in this state shall cease while such default continues.

641.416 Acquisition.—Every prepaid health clinic shall be subject to the provisions of s. 628.4615.

69O-192

624.4431 Administration; rules.—The administration of ss. 624.436-624.446 is vested in the commission and office. The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of ss. 624.436-624.446.

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee

member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.
(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.
(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.
(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a

report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

624.439 Filing of application.—The sponsoring association shall file with the office an application for a certificate of authority upon a form to be adopted by the commission and furnished by the office, signed under oath by officers of the trust, which shall include or have attached the following:
(1) A copy of the articles of incorporation, constitution, and bylaws of the association, if any.
(2) A list of the names, addresses, and official capacities within the arrangement of the individuals who are to be responsible for the management of and the conduct of the affairs of the arrangement, including all trustees, officers, and directors. Such individuals shall fully disclose to the office the extent and nature of any contracts or arrangements between themselves and the arrangement, including any possible conflicts of interest.
(3) A copy of the articles of incorporation, bylaws, or trust agreement which governs the operation of the arrangement.
(4) A copy of the policy, contract, certificate, summary plan description, or other evidence of the benefits and coverages provided to covered employees, which shall be in accordance with s. 627.651(4), and which shall include a table of the rates charged, or proposed to be charged, for each form of such contract. A qualified actuary shall certify that:
(a) The rates are not inadequate.
(b) The rates are appropriate for the class of risks for which they have been computed.
(c) An adequate description of the rating methodology has been filed with the office and such methodology follows consistent and equitable actuarial principles.
(5) A copy of the fidelity bond in an amount equal to not less than 10 percent of the funds handled annually and issued in the name of the arrangement covering its trustees, directors, officers, employees, administrator, or other individuals managing or handling the funds or assets of the arrangement. In no case may such bond be less than $50,000 or more than $500,000, except that the office, after due notice to all interested parties and opportunity for hearing, and after consideration of the record, may prescribe an amount in excess of $500,000, subject to the 10-percent limitation of the preceding sentence.
(6)(a) A copy of the arrangement's excess insurance agreement, which shall provide that the net retention level for any one risk shall not exceed $50,000, and which shall otherwise be in accordance with sound actuarial principles.
(b) The office may waive or modify the maximum net retention requirement if:
1. The excess insurance is not available for a reasonable cost; or
2. The arrangement:
a. Has 150 percent of the statutory reserve requirement as specified in s. 624.441;
b. Has a fund balance in excess of that required by statute; and
c. Has a ratio of current assets to current liabilities of at least 2.0 to 1.0.
(7)(a) A feasibility study, done by an independent qualified actuary and an independent certified public accountant, determined by the office to satisfactorily address market

potential, market penetration, market competition, operating expenses, gross revenues, net income, total assets and liabilities, cash flow, and such other items as the office or commission reasonably requires. The study shall be for the greater of 3 years or until the arrangement has been projected to be profitable for 12 consecutive months. The study must show that the arrangement would not, at any month-end of the projection period, have less than the minimum statutory deposit as required by s. 624.441 or have a fund balance less than the amount required by s. 624.4392.
(b) The feasibility study shall reflect and support that initial gross premiums for the first year of operation will be at least $100,000.
(8) Evidence satisfactory to the office showing that the arrangement will be operated in accordance with sound actuarial principles. The office shall not approve the arrangement unless the office determines that the plan is designed to provide sufficient revenues to pay current and future liabilities, as determined in accordance with sound actuarial principles.
(9) Confirmation of insolvency protection as required by s. 624.441.
(10) A copy of each contract between the arrangement and any administrator or service company which may be made available for review rather than filed or attached.
(11) Such additional information as the office or commission reasonably requires.

624.442 Annual reports; actuarial certification; quarterly reports; penalties.—
(1) Every arrangement shall, annually within 3 months after the end of the fiscal year or within such extension of time therefor as the office for good cause may grant, file a report with the office, on forms prescribed by the commission, verified by the oath of a member of the board of trustees and by an administrative executive appointed by the board, showing its condition on the last day of the preceding fiscal year. The report shall contain an audited financial statement of the arrangement prepared in accordance with statutory accounting principles, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant. The report shall also include an analysis of the adequacy of reserves and contributions or premiums charged, based on a review of past and projected claims and expenses.
(2) In addition to information called for and furnished in connection with the annual report, if reasonable grounds exist, the office may request information which summarizes paid and incurred expenses, and contributions or premiums received, and may request evidence satisfactory to the office that the arrangement is actuarially sound. Such information and evidence shall be furnished to the office by the arrangement as soon as reasonably possible after requested by the office, but not later than 30 days after such request, unless the office, for good cause, grants an extension.
(3) Annually, in conjunction with the annual report required by subsection (1), each arrangement shall submit an actuarial certification prepared by an independent actuary certifying that:
(a) The arrangement is actuarially sound. The certification shall consider the rates, benefits, and expenses of, and any other funds available for the payment of the obligations of, the arrangement.
(b) The rates being charged and to be charged for contracts are actuarially adequate through the end of the period for which rates have been guaranteed.
(c) Incurred but not reported claims and claims reported but not fully paid have been adequately provided for.
(d) Such other information relating to the performance of the arrangement as the commission or office requires.
(4) Each arrangement shall file quarterly, within 45 days after the end of each of its four quarterly reporting periods, an unaudited financial statement of the arrangement on forms prescribed by the commission, verified according to the best of their information, knowledge, and belief by the oath of a member of the board of trustees and by an

administrative executive appointed by the board showing its condition on the last day of the preceding quarter.
(5) Any arrangement that fails to file an annual financial report, actuarial report, or quarterly financial report in the form and within the time required by this section shall forfeit to the office an amount set by order of the office which does not exceed $1,000 for each of the first 10 days of noncompliance and does not exceed $2,000 for each subsequent day of noncompliance. Upon notice by the office that the arrangement is not in compliance with this section, the arrangement's authority to enroll new enrollees or to do business in this state ceases until the office determines the arrangement to be in compliance. The office may not collect more than $100,000 under this subsection with respect to any particular report.
(6) All moneys collected by the office under this section shall be deposited to the credit of the Insurance Regulatory Trust Fund.
(7) Each authorized arrangement must retain an independent certified public accountant, referred to in this subsection as "CPA," who agrees by written contract with the arrangement to comply with ss. 624.436-624.445. The contract must state that:
(a) The CPA will provide to the arrangement audited financial statements consistent with ss. 624.436-624.445.
(b) Any determination by the CPA that the arrangement does not meet the minimum surplus requirements set forth in ss. 624.436-624.445 will be stated by the CPA, in writing, in the audited financial statement.
(c) The completed workpapers and any written communications between the CPA and the arrangement will be made available for review on a visual inspection-only basis by the office at the location of the arrangement, the office, or any other reasonable place agreeable to both the office and the arrangement.
(d) The CPA will retain for review the workpapers and written communications with the arrangement for not less than 6 years.

628.4615 Specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.—
(1) For the purposes of this section, the term "specialty insurer" means any person holding a license or certificate of authority as:
(a) A motor vehicle service agreement company authorized to issue motor vehicle service agreements as those terms are defined in s. 634.011;
(b) A home warranty association authorized to issue "home warranties" as those terms are defined in s. 634.301;
(c) A service warranty association authorized to issue "service warranties" as those terms are defined in s. 634.401(13) and (14);
(d) A prepaid limited health service organization authorized to issue prepaid limited health service contracts, as those terms are defined in chapter 636;
(e) An authorized health maintenance organization operating pursuant to s. 641.21;
(f) An authorized prepaid health clinic operating pursuant to s. 641.405;
(g) A legal expense insurance corporation authorized to engage in a legal expense insurance business pursuant to s. 642.021;
(h) A provider that is licensed to operate a facility that undertakes to provide continuing care as those terms are defined in s. 651.011;
(i) A multiple-employer welfare arrangement operating pursuant to ss. 624.436-624.446;
(j) A premium finance company authorized to finance insurance premiums pursuant to s. 627.828; or
(k) A corporation authorized to accept donor annuity agreements pursuant to s. 627.481.
(2) A person may not, individually or in conjunction with any affiliated person of such person, directly or indirectly, conclude a tender offer or exchange offer for, enter into any agreement to exchange securities for, or otherwise finally acquire, 10 percent or more of

the outstanding voting securities of a specialty insurer which is a stock corporation or of a controlling company of a specialty insurer which is a stock corporation; or conclude an acquisition of, or otherwise finally acquire, 10 percent or more of the ownership interest of a specialty insurer which is not a stock corporation or of a controlling company of a specialty insurer which is not a stock corporation, unless:

(a) The person or affiliated person has filed with the office and sent by registered mail to the principal office of the specialty insurer and controlling company a letter of notification regarding the transaction or proposed transaction no later than 5 days after any form of tender offer or exchange offer is proposed, or no later than 5 days after the acquisition of the securities or ownership interest if no tender offer or exchange offer is involved. The notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;

(b) The person or affiliated person has filed with the office an application signed under oath and prepared on forms prescribed by the commission which contains the information specified in subsection (4). The application must be completed and filed within 30 days after any form of tender offer or exchange offer is proposed, or after the acquisition of the securities if no tender offer or exchange offer is involved; and

(c) The office has approved the tender offer or exchange offer, or acquisition if no tender offer or exchange offer is involved.

(3) This section does not apply to any acquisition of voting securities or ownership interest of a specialty insurer or of a controlling company by any person who, on July 9, 1986, is the owner of a majority of such voting securities or ownership interest or who, on or after July 9, 1986, becomes the owner of a majority of such voting securities or ownership interest with the approval of the office under this section. The person or affiliated person filing the required notice in paragraph (2)(a) may request the office to waive the requirements of paragraph (2)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the specialty insurer. The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the specialty insurer.

(4) The application to be filed with the office and furnished to the specialty insurer and controlling company shall contain the following information and any additional information as the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the insureds of the insurer and of the public:

(a)1. The identity of, and the background information specified in subsection (5) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and,

2. If the acquisition is to be made by, or on behalf of, a person other than a natural person and as to any person who controls, either directly or indirectly, such other person, the identity of, and the background information specified in subsection (5) on:

a. Each director, officer, or trustee, if a corporation, or

b. Each partner, owner, manager, or joint venturer, or other person performing duties similar to those of persons in the aforementioned positions, if not a corporation,

for the person.

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

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

proposals which such persons may have made to liquidate any controlling company of the specialty insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management.
(d) The nature and the extent of the controlling interest which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the controlling interest is to be acquired of a specialty insurer or controlling company which is not a stock corporation.
(e) The number of shares or other securities which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the securities are to be acquired.
(f) Information as to any contract, arrangement, or understanding with any party with respect to any of the securities of the specialty insurer or controlling company, including, but not limited to, information relating to the transfer of any of the securities, option arrangements, puts or calls, or the giving or withholding of proxies, which information names the party with whom the contract, arrangement, or understanding has been entered into and gives the details thereof.
(5)(a) The information as to the background and identity of each natural person, which information is required to be furnished pursuant to paragraph (4)(a), shall include:
1. The natural person's occupations, positions of employment, and offices held during the past 10 years.
2. The principal business and address of any business, corporation, or organization in which each such office of the natural person was held, or in which each such occupation or position of employment was carried on.
3. Whether the natural person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.
4. Whether the natural person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.
5. Whether, during the 10-year period, the natural person has been the subject of any proceeding under the federal Bankruptcy Act; or whether, during the 10-year period, any person or other business or organization in which the natural person was a director, officer, trustee, partner, owner, manager, or other official has been subject to any such proceeding, either during the time in which the natural person was a director, officer, or trustee, if a corporation, or a partner, owner, manager, joint venturer, or other official, if not a corporation, or within 12 months thereafter.
6. Whether, during the 10-year period, the natural person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law regulating the business of insurance, securities, or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities, or banking, together with details as to any such event.
7. Fingerprints of each person referred to in subsection (4).
(b) Any person filing the statement required by this section shall give all required information that is within the knowledge of:
1. The directors, officers, or trustees, if a corporation, or
2. The partners, owners, managers, or joint venturers, or others performing functions similar to those of a director, officer, or trustee, if not a corporation,

of the person making the filing and of any person controlling either directly or indirectly such person. If any material change occurs in the facts set forth in the application filed with the office pursuant to this section, an amendment setting forth such changes shall be filed immediately with the office, and a copy of the amendment shall be sent by registered mail to the principal office of the specialty insurer and to the principal office of the controlling company.

(6)(a) The acquisition application shall be reviewed in accordance with chapter 120. The office may on its own initiate, or, if requested to do so in writing by a substantially affected person, shall conduct, a proceeding to consider the appropriateness of the proposed filing. Time periods for purposes of chapter 120 shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10 days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time it finds an immediate danger to the public health, safety, and welfare of the insureds exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition disapproved and any further steps to conclude the acquisition ceased.

(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the specialty insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the specialty insurer unless advance written notice of the change in management is furnished to the office. A material change in the operation of the specialty insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the specialty insurer. A material change in the management of the specialty insurer is any change in management involving officers or directors of the specialty insurer or any person of the specialty insurer or controlling company having authority to dispose of or obligate 5 percent or more of the specialty insurer's capital or surplus. The office shall approve a material change in operations if it finds the applicable provisions of subsection (8) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (8) have not been met and in such case the specialty insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(7) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:

(a) Willfully violates this section;

(b) In violation of an order of the office issued pursuant to subsection (11), fails to divest himself or herself of any stock or ownership interest obtained in violation of this section or fails to divest himself or herself of any direct or indirect control of such stock or ownership interest, within 25 days after such order; or

(c) In violation of an order issued by the office pursuant to subsection (11), acquires an additional stock or ownership interest in a specialty insurer or controlling company or direct or indirect control of such stock or ownership interest, without complying with this section.

(8) The person or persons filing the application required by subsection (2) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed application if no proceeding is conducted, that:

(a) Upon completion of the acquisition, the specialty insurer will be able to satisfy the requirements for the issuance of a license or certificate to write the line of insurance for which it is presently licensed or certificated.

(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the specialty insurer or prejudice the interests of its insureds or the public.

(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:
1. To liquidate the specialty insurer, sell its assets, or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management, or
2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the specialty insurer,

is fair and free of prejudice to the insureds of the specialty insurer or to the public.

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the specialty insurer indicate that the acquisition is in the best interest of the insureds of the insurer and in the public interest.
(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the insureds of the specialty insurer and in the public interest to permit such persons to exercise control over the specialty insurer.
(f) The directors and officers, if such specialty insurer or controlling company is a stock corporation, or the trustees, partners, owners, managers, or joint venturers or other persons performing duties similar to those of persons in the aforementioned positions, if such specialty insurer or controlling company is not a stock corporation, to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation.
(g) The management of the specialty insurer after the acquisition will be competent and trustworthy, and will possess sufficient managerial experience so as to make the proposed operation of the specialty insurer not hazardous to the insurance-buying public.
(h) The management of the specialty insurer after the acquisition shall not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto.
(i) The acquisition is not likely to be hazardous or prejudicial to the insureds of the insurer or to the public.
(j) The effect of the acquisition would not substantially lessen competition in the line of insurance for which the specialty insurer is licensed or certified in this state or would not tend to create a monopoly therein.
(9) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition contrary to the provisions of this section is void. Upon the petition of the specialty insurer or the controlling company, the circuit court for the county in which the principal office of the specialty insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the provisions of this section. There shall be a private right of action in favor of the specialty insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the specialty insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by the specialty insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of an application pursuant to this section, or who files such an application, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.

(10) Any approval by the office under this section does not constitute a recommendation by the office of the tender offer or exchange offer, or acquisition, if no tender offer or exchange offer is involved. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.
(11) If the office determines that any person or any affiliated person of such person has acquired 10 percent or more of the outstanding voting securities of a specialty insurer or controlling company which is a stock corporation, or 10 percent or more of the ownership interest of a specialty insurer or controlling company which is not a stock corporation, without complying with the provisions of this section, the office may order that the person and any affiliated person of such person cease acquisition of the specialty insurer or controlling company and, if appropriate, divest itself of any stock or ownership interest acquired in violation of this section.
(12)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any specialty insurer or controlling company acquired in violation of this section.
(b) If any specialty insurer is subject to suspension or revocation pursuant to paragraph (a), the specialty insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its insureds, creditors, or stockholders or to the public.
(13)(a) For the purpose of this section, the term "acquisition" includes:
1. A tender offer or exchange offer for securities, assets, or other ownership interest;
2. An agreement to exchange securities for other securities, assets, or other ownership interest;
3. A merger of a person or affiliated person into a specialty insurer or a merger of any person with a specialty insurer;
4. A consolidation; or
5. Any other form of change of control

whereby any person or affiliated person acquires or attempts to acquire, directly or indirectly, 10 percent or more of the ownership interest or assets of a specialty insurer or of a controlling company. However, in the case of a health maintenance organization organized as a for-profit corporation, the provisions of s. 628.451 shall govern with respect to any merger or consolidation, and, in the case of a health maintenance organization organized as a not-for-profit corporation, the provisions of s. 628.471 shall govern with respect to any merger or consolidation.

(b) For the purpose of this section, the term "affiliated person" of another person includes:
1. The spouse of such other natural person;
2. The parents of such other natural person and their lineal descendants and the parents of such other natural person's spouse and their lineal descendants;
3. Any person who directly or indirectly owns or controls, or holds with power to vote, 10 percent or more of the outstanding voting securities of such other person;
4. Any person who directly or indirectly owns 10 percent or more of the outstanding voting securities which are directly or indirectly owned or controlled, or held with power to vote, by such other person;
5. Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;
6. Any director, officer, trustee, partner, owner, manager, joint venturer, or employee, or other person performing duties similar to those of persons in the aforementioned positions, of such other person;

7. If such other person is an investment company, any investment adviser of such company or any member of an advisory board of such company;
8. If such other person is an unincorporated investment company not having a board of directors, the depositor of such company; or
9. Any person who has entered into an agreement, written or unwritten, to act in concert with such other person in acquiring, or limiting the disposition of, securities of a specialty insurer or controlling company which is a stock corporation or in acquiring, or limiting the disposition of, an ownership interest of a specialty insurer or controlling company which is not a stock corporation.

(c) For the purposes of this section, the term "controlling company" means any corporation, trust, or association owning, directly or indirectly, 25 percent or more of the voting securities of one or more specialty insurance companies which are stock corporations, or 25 percent or more of the ownership interest of one or more specialty insurance companies which are not stock corporations.

(d) For the purpose of this section, the term "natural person" means an individual.

(e) For the purpose of this section, the term "person" includes a natural person, corporation, association, trust, general partnership, limited partnership, joint venture, firm, proprietorship, or any other entity which may hold a license or certificate as a specialty insurer.

(14) The commission may adopt, amend, or repeal rules that are necessary to implement the provisions of this section, pursuant to chapter 120.

690-157

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

627.9407 Disclosure, advertising, and performance standards for long-term care insurance.—
(1) STANDARDS.—The commission shall adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures of the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, disclosure of tax consequences, benefit triggers, prohibition against post-claims underwriting, reporting requirements, standards for marketing, and definitions of terms.

627.9408 Rules.—
(1) The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to administer this part.
(2) The commission may adopt by rule the provisions of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in the second quarter of the year 2000 which are not in conflict with the Florida Insurance Code.

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

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.
(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by

anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.
(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.
(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:
(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.
(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.
(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.
(b) Insurers must:
1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).
2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

627.9402 Purpose.—The purpose of this part is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

[1]627.410 Filing, approval of forms.—

(7) Each insurer subject to subsection (6) shall make an annual filing with the office within 12 months after its previous filing, demonstrating the reasonableness of benefits in relation

to premium rates. After receiving a request to be exempted from the provisions of this section, the office may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(a) The filing shall be satisfied by one of the following methods:

1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules adopted by the commission.

2. If no rate change is proposed, a filing that consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the commission.

(b) As used in this section, the term "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants who have a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.

(c) If at the time a filing is required an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office by the date the filing is due.

(d) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days after the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made until such time as the office determines that the required filing is properly submitted.

M E M O R A N D U M

DATE: May 17, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for June 14, 2017
Request for Final Approval to Adopt Repeal of
Rules 69O-167.015, 69O-171.004, 69O-176.022, 69O.185.007, 69O-189.007, F.A.C.
Assignment #199194-16

The Office of Insurance Regulation requests that these proposed rule repeals be presented to the Cabinet aides on or before June 7, 2017 and to the Financial Services Commission on June 14, 2017, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on May 18, 2017.

The notice of proposed rules was published on March 21, 2017 in Volume 43, No. 55, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

Sections 624.308(1), 624.307(1), 624.424(1)(c) 627.215, 627.913(1), 627.918(1), 627.745, 626.171, 635.081, 635.071(2), F.S., provide rulemaking authority and laws implemented for these rules.

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

Stephen Fredrickson 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-167.015 Home Structure Rating System Adopted.

Rulemaking Authority 624.308(1) FS., Ch. 2007-1, Laws of Florida, § 40; Ch. 2006-12, Laws of Florida, § 39. Law Implemented 624.307(1) FS., Ch. 2007-1, Laws of Florida, § 40. History–New 11-1-07 Repealed.

69O-171.004 Reports of Information by Products Liability Insurers Required.

Rulemaking ~~Specific~~ Authority 624.308(1) FS. Law Implemented 624.307(1), 627.913(1), 627.918(1) FS. History–New 1-16-83, Amended 7-1-85, Formerly 4-59.04, 4-59.004, 4-171.004 Repealed _____.

69O-176.022 Mediation of Bodily Injury and Property Damage Claims.

Rulemaking ~~Specific~~ Authority 624.308(1), 627.745(4) FS. Law Implemented 624.307(1), 626.171, 627.745 FS. History–New 3-14-93, Amended 8-6-98, 9-17-01, Formerly 4-176.022 Repealed _____.

69O-185.007 Insurer to Maintain and File Records.

Rulemaking ~~Specific~~ Authority 635.081 FS. Law Implemented 635.071(2) FS. History–Repromulgated 12-24-74, Amended 4-17-84, 4-30-86, Formerly 4-2.11, 4-2.011, 4-185.007 Repealed _____.

69O-189.007 Insurer Experience Reporting - Excessive Profits, Workers' Compensation Insurance.

Rulemaking ~~Specific~~ Authority 624.308(1), 627.215 FS. Law Implemented 624.307(1), 624.424(1)(c), 627.215 FS. History–New 6-14-84, Amended 7-1-85, Formerly 4-59.061, Amended 6-1-88, Formerly 4-59.0061, Amended 12-20-00, Formerly 4-189.007, Amended 3-29-05 Repealed .

Rulemaking Authority

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

627.215 Excessive profits for commercial property and commercial casualty insurance prohibited.—
(1)(a) Each insurer group writing commercial property insurance as defined in s. 627.0625, commercial umbrella liability insurance as defined in s. 627.0625, or commercial casualty insurance as defined in s. 627.0625 shall file with the office before July 1 of each year, on a form prescribed by the commission, the following data for the component types of such insurance as provided in the form:
1. Calendar-year earned premium.
2. Accident-year incurred losses and loss adjustment expenses.
3. The administrative and selling expenses incurred in this state or allocated to this state for the calendar year.
4. Policyholder dividends applicable to the calendar year.

This paragraph does not prohibit an insurer from filing on a calendar-year basis.

(b) The data filed for the group shall be a consolidation of the data of the individual insurers of the group. However, an insurer may elect to consolidate commercial umbrella liability insurance data with commercial casualty insurance data or to separately file data for commercial umbrella liability insurance. Each insurer shall elect its method of filing commercial umbrella liability insurance at the time of filing data for accident year 1987 and shall thereafter continue filing under the same method. In the case of commercial umbrella liability insurance data reported separately, a separate excessive profits test shall be applied and the test period shall be 10 years.
(2)(a) Each insurer group writing commercial property insurance or commercial casualty insurance shall also file a schedule of Florida loss and loss adjustment experience for each of the 3 years previous to the most recent accident year. The incurred losses and loss adjustment expenses shall be valued as of December 31 of the first year following the latest accident year, developed to an ultimate basis, and at two 12-month intervals thereafter, each developed to an ultimate basis, so that a total of 3 evaluations will be provided for each accident year. For reporting purposes unrelated to determining excess profits, the loss and loss adjustment experience of each accident year shall continue to be reported until each accident year has been reported at eight stages of development.
(b) Each insurer group writing commercial umbrella liability insurance which elects to file separate data for such insurance shall also file a schedule of Florida loss and loss adjustment experience for each of the 10 years previous to the most recent accident year. The incurred losses and loss adjustment expenses shall be valued as of December 31 of the first year following the latest accident year, developed to an ultimate basis, and at nine 12-month intervals thereafter, each developed to an ultimate basis, so that a total of 10 evaluations will be provided for each accident year.
(3) Each insurer group's underwriting gain or loss for each calendar-accident year shall be computed as follows: The sum of the accident-year incurred losses and loss adjustment expenses as of December 31 of the year, developed to an ultimate basis, plus the administrative and selling expenses incurred in the calendar year, plus policyholder

dividends applicable to the calendar year, shall be subtracted from the calendar-year earned premium to determine the underwriting gain or loss.
(4) For the 3 most recent calendar-accident years for which data is to be filed under this section, the underwriting gain or loss shall be compared to the anticipated underwriting profit, except in the case of separately reported commercial umbrella liability insurance for which such comparison shall be made for the 10 most recent calendar-accident years.
(5)(a) Beginning with the July 1, 1991, report for commercial property insurance and commercial casualty insurance, an excessive profit has been realized if the net aggregate underwriting gain for these lines combined is greater than the net aggregate anticipated underwriting profit for these lines plus 5 percent of earned premiums for the 3 most recent calendar years for which data is to be filed under this section. For calculation purposes commercial property insurance and commercial casualty insurance shall be broken down into sublines in order to ascertain the anticipated underwriting profit factor versus the actual underwriting gain for the given subline.
(b) Beginning with the July 1, 1998, report for commercial umbrella liability insurance, if an insurer has elected to file data separately for such insurance, an excessive profit has been realized if the underwriting gain for such insurance is greater than the anticipated underwriting profit for such insurance plus 5 percent of earned premiums for the 10 most recent calendar years for which data is to be filed under this section.
(6) As used in this section with respect to any 3-year period, or with respect to any 10-year period in the case of commercial umbrella liability insurance, "anticipated underwriting profit" means the sum of the dollar amounts obtained by multiplying, for each rate filing of the insurer group in effect during such period, the earned premiums applicable to such rate filing during such period by the percentage factor included in such rate filing for profit and contingencies, such percentage factor having been determined with due recognition to investment income from funds generated by Florida business, except that the anticipated underwriting profit for the purposes of this section shall be calculated using a profit and contingencies factor that is not less than zero. Separate calculations need not be made for consecutive rate filings containing the same percentage factor for profits and contingencies.
(7) If the insurer group has realized an excessive profit, the office shall order a return of the excessive amounts after affording the insurer group an opportunity for hearing and otherwise complying with the requirements of chapter 120. Such excessive amounts shall be refunded in all instances unless the insurer group affirmatively demonstrates to the office that the refund of the excessive amounts will render a member of the insurer group financially impaired or will render it insolvent under the provisions of the Florida Insurance Code.
(8) Any excess profit of an insurance company shall be returned to policyholders in the form of a cash refund or a credit toward the future purchase of insurance. The excessive amount shall be refunded on a pro rata basis in relation to the final compilation year earned premiums to the policyholders of record of the insurer group on December 31 of the final compilation year.
(9)(a) Cash refunds to policyholders may be rounded to the nearest dollar.
(b) Data in required reports to the office may be rounded to the nearest dollar.
(c) Rounding, if elected by the insurer, shall be applied consistently.
(10)(a) Refunds shall be completed in one of the following ways:
1. If the insurer group elects to make a cash refund, the refund shall be completed within 60 days after entry of a final order indicating that excessive profits have been realized.
2. If the insurer group elects to make refunds in the form of a credit to renewal policies, such credits shall be applied to policy renewal premium notices which are forwarded to insureds more than 60 calendar days after entry of a final order indicating that excessive profits have been realized. If an insurer group has made this election but an insured thereafter cancels her or his policy or otherwise allows the policy to terminate, the insurer group shall make a cash refund within 60 days after termination of such coverage.

(b) Upon completion of the renewal credits or refund payments, the insurer group shall immediately certify to the office that the refunds have been made.
(11) Any refund or renewal credit made pursuant to this section shall be treated as a policyholder dividend applicable to the year immediately succeeding the compilation period giving rise to the refund or credit, for purposes of reporting under this section for subsequent years.
(12) The application of this law to commercial property and commercial casualty insurance, which includes commercial umbrella liability insurance, ceases on January 1, 1997.

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

624.424 Annual statement and other information.—

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

635.081 Administration and enforcement.—The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter and shall have the same powers of administration and enforcement of the provisions of this chapter as it has with respect to casualty or surety insurers in general under the Florida Insurance Code.

635.071 Filings, approval of forms; rate filings.—

(2) Each insurer shall file with the office for informational purposes the rate to be charged and the premium to be paid by the policyholder, including all modifications of rates and premiums.

627.745 Mediation of claims.—
(1)(a) In any claim filed with an insurer for personal injury in an amount of $10,000 or less or any claim for property damage in any amount, arising out of the ownership, operation, use, or maintenance of a motor vehicle, either party may demand mediation of the claim prior to the institution of litigation.
(b) A request for mediation shall be filed with the department on a form approved by the department. The request for mediation shall state the reason for the request for mediation and the issues in dispute which are to be mediated. The filing of a request for mediation tolls the applicable time requirements for filing suit for a period of 60 days following the conclusion of the mediation process or the time prescribed in s. 95.11, whichever is later.
(c) The insurance policy must specify in detail the terms and conditions for mediation of a first-party claim.
(d) The mediation shall be conducted as an informal process in which formal rules of evidence and procedure need not be observed. Any party participating in a mediation must have the authority to make a binding decision. All parties must mediate in good faith.
(e) The department shall randomly select mediators. Each party may once reject the mediator selected, either originally or after the opposing side has exercised its option to reject a mediator.

(f) Costs of mediation shall be borne equally by both parties unless the mediator determines that one party has not mediated in good faith.
(g) Only one mediation may be requested for each claim, unless all parties agree to further mediation.
(2) Upon receipt of a request for mediation, the department shall refer the request to a mediator. The mediator shall notify the applicant and all interested parties, as identified by the applicant, and any other parties the mediator believes may have an interest in the mediation, of the date, time, and place of the mediation conference. The conference may be held by telephone, if feasible. The mediation conference shall be held within 45 days after the request for mediation.
(3)(a) The department shall approve mediators to conduct mediations pursuant to this section. All mediators must file an application under oath for approval as a mediator.
(b) To qualify for approval as a mediator, an individual must meet one of the following qualifications:
1. Possess an active certification as a Florida Supreme Court certified circuit court mediator. A Florida Supreme Court certified circuit court mediator in a lapsed, suspended, sanctioned, or decertified status is not eligible to participate in the mediation program.
2. Be an approved department mediator as of July 1, 2014, and have conducted at least one mediation on behalf of the department within 4 years immediately preceding that date.
(4) The department shall deny an application, or suspend or revoke its approval, of a mediator to serve in such capacity if the department finds that one or more of the following grounds exist:
(a) Lack of one or more of the qualifications specified in this section for approval.
(b) Material misstatement, misrepresentation, or fraud in obtaining or attempting to obtain the approval.
(c) Demonstrated lack of fitness or trustworthiness to act as a mediator.
(d) Fraudulent or dishonest practices in the conduct of mediation or in the conduct of business in the financial services industry.
(e) Violation of any provision of this code or of a lawful order or rule of the department, violation of the Florida Rules for Certified and Court-Appointed Mediators, or aiding, instructing, or encouraging another party in committing such a violation.

The department may adopt rules to administer this subsection.

(5) The department must adopt rules of procedure for claims mediation, taking into consideration a system which:
(a) Is fair.
(b) Promotes settlement.
(c) Avoids delay.
(d) Is nonadversarial.
(e) Uses a framework for modern mediating technique.
(f) Controls costs and expenses of mediation.
(6) Disclosures and information divulged in the mediation process are not admissible in any subsequent action or proceeding relating to the claim or to the cause of action giving rise to the claim. A person demanding mediation under this section may not demand or request mediation after a suit is filed relating to the same facts already mediated.

626.171 Application for license as an agent, customer representative, adjuster, service representative, managing general agent, or reinsurance intermediary.—
(1) The department may not issue a license as agent, customer representative, adjuster, service representative, managing general agent, or reinsurance intermediary to any person except upon written application filed with the department, meeting the qualifications for the

license applied for as determined by the department, and payment in advance of all applicable fees. The application must be made under the oath of the applicant and be signed by the applicant. An applicant may permit a third party to complete, submit, and sign an application on the applicant's behalf, but is responsible for ensuring that the information on the application is true and correct and is accountable for any misstatements or misrepresentations. The department shall accept the uniform application for nonresident agent licensing. The department may adopt revised versions of the uniform application by rule.

(2) In the application, the applicant shall set forth:

[1](a) His or her full name, age, social security number, residence address, business address, mailing address, contact telephone numbers, including a business telephone number, and e-mail address.

(b) A statement indicating the method the applicant used or is using to meet any required prelicensing education, knowledge, experience, or instructional requirements for the type of license applied for.

(c) Whether he or she has been refused or has voluntarily surrendered or has had suspended or revoked a license to solicit insurance by the department or by the supervising officials of any state.

(d) Whether any insurer or any managing general agent claims the applicant is indebted under any agency contract or otherwise and, if so, the name of the claimant, the nature of the claim, and the applicant's defense thereto, if any.

(e) Proof that the applicant meets the requirements for the type of license for which he or she is applying.

(f) The applicant's gender (male or female).

(g) The applicant's native language.

(h) The highest level of education achieved by the applicant.

(i) The applicant's race or ethnicity (African American, white, American Indian, Asian, Hispanic, or other).

(j) Such other or additional information as the department may deem proper to enable it to determine the character, experience, ability, and other qualifications of the applicant to hold himself or herself out to the public as an insurance representative.

However, the application must contain a statement that an applicant is not required to disclose his or her race or ethnicity, gender, or native language, that he or she will not be penalized for not doing so, and that the department will use this information exclusively for research and statistical purposes and to improve the quality and fairness of the examinations.

(3) Each application shall be accompanied by payment of any applicable fee.

(4) An applicant for a license as an agent, customer representative, adjuster, service representative, managing general agent, or reinsurance intermediary must submit a set of the individual applicant's fingerprints, or, if the applicant is not an individual, a set of the fingerprints of the sole proprietor, majority owner, partners, officers, and directors, to the department and must pay the fingerprint processing fee set forth in s. 624.501. Fingerprints shall be used to investigate the applicant's qualifications pursuant to s. 626.201. The fingerprints shall be taken by a law enforcement agency, designated examination center, or other department-approved entity. The department shall require all designated examination centers to have fingerprinting equipment and to take fingerprints from any applicant or prospective applicant who pays the applicable fee. The department may not approve an application for licensure as an agent, customer service representative, adjuster, service representative, managing general agent, or reinsurance intermediary if fingerprints have not been submitted.

(5) The application for license filing fee prescribed in s. 624.501 is not subject to refund.

(6) Members of the United States Armed Forces and their spouses, and veterans of the United States Armed Forces who have retired within 24 months before application for licensure, are exempt from the application filing fee prescribed in s. 624.501. Qualified individuals must provide a copy of a military identification card, military dependent identification card, military service record, military personnel file, veteran record, discharge paper, or separation document, or a separation document that indicates such members of the United States Armed Forces are currently in good standing or were honorably discharged.
(7) Pursuant to the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, each party is required to provide his or her social security number in accordance with this section. Disclosure of social security numbers obtained through this requirement shall be limited to the purpose of administration of the Title IV-D program for child support enforcement.

627.913 Reports by products liability insurers.—The office may require any insurer authorized to write a policy of products liability insurance in the state to transmit the following information, based on its statewide products liability insurance writings. Upon the request of the office, an insurer shall, within 60 days, submit to the office a report that contains:
(1) Premiums written;

627.918 Reporting formats.—
(1) The office shall require that the reporting provided for in this part be made on forms established by the commission or in a format compatible with the office's electronic data processing equipment.

M E M O R A N D U M

DATE: May 26, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for June 14, 2017
Request for Approval to Publish Repeal of
Rule 69O-125.002
Assignment # 208589-17

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before June 7, 2017 and to the Financial Services Commission on June 14, 2017, with a request to approve for publication the proposed rule.

This rule has become obsolete due to changes in the law governing the approval of multi-policy discounts. Section 627.0655, F.S. as amended, now has codified the contents of the rule and accordingly the rule is no longer necessary.

Sections 624.308(1), 626.9611, 624.307(1), 626.9541(1)(g), 627.062, 627.0651, 627.072, 627.151, F.S., provide rulemaking authority and laws implemented for this rule.

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

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

69O-125.002 Unfair Discrimination in Insurance Rates - Multi-policy Discounts.

Rulemaking ~~Specific~~ Authority 624.308(1), 626.9611 FS. Law Implemented 624.307(1), 626.9541(1)(g), 627.062, 627.0651, 627.072, 627.151 FS. History– New 2-7-85, Formerly 4-43.06, 4-43.006, 4-125.002 Repealed_____.

69O-125.002

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

626.9611 Rules.—
(1) The department or commission may, in accordance with chapter 120, adopt reasonable rules as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by s. 626.9541 or s. 626.9551, but the rules shall not enlarge upon or extend the provisions of ss. 626.9541 and 626.9551.
(2) The department and the commission shall, in accordance with chapter 120, adopt rules to protect members of the United States Armed Forces from dishonest or predatory insurance sales practices by insurers and insurance agents. The rules shall identify specific false, misleading, deceptive, or unfair methods of competition, acts, or practices which are prohibited by s. 626.9541 or s. 626.9551. The rules shall be based upon model rules or model laws adopted by the National Association of Insurance Commissioners which identify certain insurance practices involving the solicitation or sale of insurance and annuities to members of the United States Armed Forces which are false, misleading, deceptive, or unfair.

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

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—
(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(g) Unfair discrimination.—
1. Knowingly making or permitting unfair discrimination between individuals of the same actuarially supportable class and equal expectation of life, in the rates charged for a life insurance or annuity contract, in the dividends or other benefits payable thereon, or in any other term or condition of such contract.
2. Knowingly making or permitting unfair discrimination between individuals of the same actuarially supportable class, as determined at the time of initial issuance of the coverage, and essentially the same hazard, in the amount of premium, policy fees, or rates charged for a policy or contract of accident, disability, or health insurance, in the benefits payable thereunder, in the terms or conditions of such contract, or in any other manner.
3. For a health insurer, life insurer, disability insurer, property and casualty insurer, automobile insurer, or managed care provider to underwrite a policy, or refuse to issue, reissue, or renew a policy, refuse to pay a claim, cancel or otherwise terminate a policy, or increase rates based upon the fact that an insured or applicant who is also the proposed insured has made a claim or sought or should have sought medical or psychological treatment in the past for abuse, protection from abuse, or shelter from abuse, or that a

claim was caused in the past by, or might occur as a result of, any future assault, battery, or sexual assault by a family or household member upon another family or household member as defined in s. 741.28. A health insurer, life insurer, disability insurer, or managed care provider may refuse to underwrite, issue, or renew a policy based on the applicant's medical condition, but may not consider whether such condition was caused by an act of abuse. For purposes of this section, the term "abuse" means the occurrence of one or more of the following acts:

a. Attempting or committing assault, battery, sexual assault, or sexual battery;
b. Placing another in fear of imminent serious bodily injury by physical menace;
c. False imprisonment;
d. Physically or sexually abusing a minor child; or
e. An act of domestic violence as defined in s. 741.28.

This subparagraph does not prohibit a property and casualty insurer or an automobile insurer from excluding coverage for intentional acts by the insured if such exclusion is not an act of unfair discrimination as defined in this paragraph.

4. For a personal lines property or personal lines automobile insurer to:

a. Refuse to issue, reissue, or renew a policy; cancel or otherwise terminate a policy; or charge an unfairly discriminatory rate in this state based on the lawful use, possession, or ownership of a firearm or ammunition by the insurance applicant, insured, or a household member of the applicant or insured. This sub-subparagraph does not prevent an insurer from charging a supplemental premium that is not unfairly discriminatory for a separate rider voluntarily requested by the insurance applicant to insure a firearm or a firearm collection whose value exceeds the standard policy coverage.

b. Disclose the lawful ownership or possession of firearms of an insurance applicant, insured, or household member of the applicant or insured to a third party or an affiliated entity of the insurer unless the insurer discloses to the applicant or insured the specific need to disclose the information and the applicant or insured expressly consents to the disclosure, or the disclosure is necessary to quote or bind coverage, continue coverage, or adjust a claim. For purposes of underwriting and issuing insurance coverage, this sub-subparagraph does not prevent the sharing of information between an insurance company and its licensed insurance agent if a separate rider has been voluntarily requested by the policyholder or prospective policyholder to insure a firearm or a firearm collection whose value exceeds the standard policy coverage.

627.062 Rate standards.—

(1) The rates for all classes of insurance to which the provisions of this part are applicable may not be excessive, inadequate, or unfairly discriminatory.

(2) As to all such classes of insurance:

(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals that allow the insurer a reasonable rate of return on the classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, must be filed with the office under one of the following procedures:

1. If the filing is made at least 90 days before the proposed effective date and is not implemented during the office's review of the filing and any proceeding and judicial review, such filing is considered a "file and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act.

Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings does not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.

2. If the filing is not made in accordance with subparagraph 1., such filing must be made as soon as practicable, but within 30 days after the effective date, and is considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders those portions of rates found to be excessive, as provided in paragraph (h).

3. For all property insurance filings made or submitted after January 25, 2007, but before May 1, 2012, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered property coverages.

(b) Upon receiving a rate filing, the office shall review the filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:

1. Past and prospective loss experience within and without this state.
2. Past and prospective expenses.
3. The degree of competition among insurers for the risk insured.
4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers calculate investment income attributable to classes of insurance written in this state and the manner in which investment income is used to calculate insurance rates. Such manner must contemplate allowances for an underwriting profit factor and full consideration of investment income that produces a reasonable rate of return; however, investment income from invested surplus may not be considered.
5. The reasonableness of the judgment reflected in the filing.
6. Dividends, savings, or unabsorbed premium deposits allowed or returned to policyholders, members, or subscribers in this state.
7. The adequacy of loss reserves.
8. The cost of reinsurance. The office may not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer's estimated 250-year probable maximum loss or any lower level of loss.
9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.
10. Conflagration and catastrophe hazards, if applicable.
11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.
12. Projected flood losses for personal residential property insurance, if applicable, which may be estimated using a model or method, or a straight average of model results or output ranges, independently found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology and as further provided in s. 627.0628.
13. A reasonable margin for underwriting profit and contingencies.
14. The cost of medical services, if applicable.
15. Other relevant factors that affect the frequency or severity of claims or expenses.

(c) In the case of fire insurance rates, consideration must be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.
(d) If conflagration or catastrophe hazards are considered by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and maintain the premium in a catastrophe reserve. Removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes must be approved by the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes must be placed in the catastrophe reserve.
(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), the office may find a rate to be excessive, inadequate, or unfairly discriminatory based upon the following standards:
1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business which is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.
2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, if the replenishment is attributable to investment losses.
3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.
4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625.
5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.
6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.
(f) In reviewing a rate filing, the office may require the insurer to provide, at the insurer's expense, all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.
(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being notified, the insurer or rating organization shall, within 60 days, file with the office all information that, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer may not alter the rate except to conform to the office's notice until the earlier of 120 days after the date the

notification was provided or 180 days after the date of implementing the rate. The office, subject to chapter 120, may disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(h) If the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule, which responds to the findings of the office, be filed by the insurer. The office shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to the policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding is applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(i) Except as otherwise specifically provided in this chapter, for property and casualty insurance the office may not directly or indirectly:

1. Prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing; or

2. Impede, abridge, or otherwise compromise an insurer's right to acquire policyholders, advertise, or appoint agents, including the calculation, manner, or amount of such agent commissions, if any.

(j) With respect to residential property insurance rate filings, the rate filing must account for mitigation measures undertaken by policyholders to reduce hurricane losses.

(k)1. A residential property insurer may make a separate filing limited solely to an adjustment of its rates for reinsurance, the cost of financing products used as a replacement for reinsurance, financing costs incurred in the purchase of reinsurance, and the actual cost paid due to the application of the cash build-up factor pursuant to s. 215.555(5)(b) if the insurer:

a. Elects to purchase financing products such as a liquidity instrument or line of credit, in which case the cost included in filing for the liquidity instrument or line of credit may not result in a premium increase exceeding 3 percent for any individual policyholder. All costs contained in the filing may not result in an overall premium increase of more than 15 percent for any individual policyholder.

b. Includes in the filing a copy of all of its reinsurance, liquidity instrument, or line of credit contracts; proof of the billing or payment for the contracts; and the calculation upon which the proposed rate change is based demonstrating that the costs meet the criteria of this section.

2. An insurer that purchases reinsurance or financing products from an affiliated company may make a separate filing only if the costs for such reinsurance or financing products are charged at or below charges made for comparable coverage by nonaffiliated reinsurers or financial entities making such coverage or financing products available in this state.

3. An insurer may make only one filing per 12-month period under this paragraph.

4. An insurer that elects to implement a rate change under this paragraph must file its rate filing with the office at least 45 days before the effective date of the rate change. After an insurer submits a complete filing that meets all of the requirements of this paragraph, the office has 45 days after the date of the filing to review the rate filing and determine if the rate is excessive, inadequate, or unfairly discriminatory.

The provisions of this subsection do not apply to workers' compensation, employer's liability insurance, and motor vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules filed with the office and that have been submitted to the insurer for individual rating, the insurer must maintain documentation on each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for at least 5 years after the effective date of the policy.

(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.

(c) This subsection does not apply to private passenger motor vehicle insurance.

(d)1. The following categories or kinds of insurance and types of commercial lines risks are not subject to paragraph (2)(a) or paragraph (2)(f):

a. Excess or umbrella.

b. Surety and fidelity.

c. Boiler and machinery and leakage and fire extinguishing equipment.

d. Errors and omissions.

e. Directors and officers, employment practices, fiduciary liability, and management liability.

f. Intellectual property and patent infringement liability.

g. Advertising injury and Internet liability insurance.

h. Property risks rated under a highly protected risks rating plan.

i. General liability.

j. Nonresidential property, except for collateral protection insurance as defined in s. 624.6085.

k. Nonresidential multiperil.

l. Excess property.

m. Burglary and theft.

n. Travel insurance, if issued as a master group policy with a situs in another state where each certificateholder pays less than $30 in premium for each covered trip and where the insurer has written less than $1 million in annual written premiums in the travel insurance product in this state during the most recent calendar year.

o. Medical malpractice for a facility that is not a hospital licensed under chapter 395, a nursing home licensed under part II of chapter 400, or an assisted living facility licensed under part I of chapter 429.

p. Medical malpractice for a health care practitioner who is not a dentist licensed under chapter 466, a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, a pharmacist licensed under chapter 465, or a pharmacy technician registered under chapter 465.

q. Any other commercial lines categories or kinds of insurance or types of commercial lines risks that the office determines should not be subject to paragraph (2)(a) or paragraph (2)(f) because of the existence of a competitive market for such insurance or similarity of such insurance to other categories or kinds of insurance not subject to paragraph (2)(a) or paragraph (2)(f), or to improve the general operational efficiency of the office.

2. Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on insurance and risks described in subparagraph 1. which are written in this state.

3. An insurer shall notify the office of any changes to rates for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The

notice must include the name of the insurer, the type or kind of insurance subject to rate change, and the average statewide percentage change in rates. Actuarial data with regard to rates for such risks must be maintained by the insurer for 2 years after the effective date of changes to those rates and are subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b), (c), and (d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

4. A rating organization shall notify the office of any changes to loss cost for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to paragraph (2)(a) or paragraph (2)(f) must be maintained by the rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b)-(d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

(4) The establishment of any rate, rating classification, rating plan or schedule, or variation thereof in violation of part IX of chapter 626 is also in violation of this section.

(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the fund, together with reasonable costs of other reinsurance; however, except as otherwise provided in this section, the insurer may not recoup reinsurance costs that duplicate coverage provided by the fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium, and any over-recoupment must be subtracted from the following year's reimbursement premium.

(6)(a) If an insurer requests an administrative hearing pursuant to s. 120.57 related to a rate filing under this section, the director of the Division of Administrative Hearings shall expedite the hearing and assign an administrative law judge who shall commence the hearing within 30 days after the receipt of the formal request and enter a recommended order within 30 days after the hearing or within 30 days after receipt of the hearing transcript by the administrative law judge, whichever is later. Each party shall have 10 days in which to submit written exceptions to the recommended order. The office shall enter a final order within 30 days after the entry of the recommended order. The provisions of this paragraph may be waived upon stipulation of all parties.

(b) Upon entry of a final order, the insurer may request an expedited appellate review pursuant to the Florida Rules of Appellate Procedure. It is the intent of the Legislature that the First District Court of Appeal grant an insurer's request for an expedited appellate review.

(7) The provisions of this subsection apply only to rates for medical malpractice insurance and control to the extent of any conflict with other provisions of this section.

(a) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base and used to justify a rate or rate change. Any common-law bad faith action identified as such, any portion of a settlement entered as a result of a statutory or common-law action, or any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not

be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages may not be included in the insurer's rate base and used to justify a rate or rate change.
(b) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, using loss experience solely for this state or giving greater credibility to this state's loss data after applying actuarially sound methods of assigning credibility to such data.
(c) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.
(d) The insurer must apply a discount or surcharge based on the health care provider's loss experience or establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used, and provide a copy, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.
(e) For medical malpractice rates subject to paragraph (2)(a), the medical malpractice insurer shall make a rate filing under this section, sworn to by at least two executive officers of the insurer, at least once each calendar year.
(8)(a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a property rate filing subject to paragraph (2)(a):
1. The signing officer and actuary have reviewed the rate filing;
2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading;
3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and
4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.
(b) A signing officer or actuary who knowingly makes a false certification under this subsection commits a violation of s. 626.9541(1)(e) and is subject to the penalties under s. 626.9521.
(c) Failure to provide such certification by the officer and actuary shall result in the rate filing being disapproved without prejudice to be refiled.
(d) The certification made pursuant to paragraph (a) is not rendered false if, after making the subject rate filing, the insurer provides the office with additional or supplementary information pursuant to a formal or informal request from the office. However, the actuary who is primarily responsible for preparing and submitting such information must certify the information in accordance with the certification required under paragraph (a) and the penalties in paragraph (b), except that the chief executive officer, chief financial officer, or chief actuary need not certify the additional or supplementary information.
(e) The commission may adopt rules and forms to administer this subsection.
(9) The burden is on the office to establish that rates are excessive for personal lines residential coverage with a dwelling replacement cost of $1 million or more or for a single condominium unit with a combined dwelling and contents replacement cost of $1 million or

more. Upon request of the office, the insurer shall provide such loss and expense information as the office reasonably needs to meet this burden.
(10) Any interest paid pursuant to s. 627.70131(5) may not be included in the insurer's rate base and may not be used to justify a rate or rate change.

627.0651 Making and use of rates for motor vehicle insurance.—
(1) Insurers shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on motor vehicle insurance written in this state. A copy of rates, rating schedules, and rating manuals, and changes therein, shall be filed with the office under one of the following procedures:
(a) If the filing is made at least 60 days before the proposed effective date and the filing is not implemented during the office's review of the filing and any proceeding and judicial review, such filing shall be considered a "file and use" filing. In such case, the office shall initiate proceedings to disapprove the rate and so notify the insurer or shall finalize its review within 60 days after receipt of the filing. Notification to the insurer by the office of its preliminary findings shall toll the 60-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue notice to the insurer of its preliminary findings within 60 days after the filing.
(b) If the filing is not made in accordance with the provisions of paragraph (a), such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders portions of rates found to be excessive, as provided in subsection (11).
(2) Upon receiving notice of a rate filing or rate change, the office shall review the rate or rate change to determine if the rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall in accordance with generally accepted and reasonable actuarial techniques consider the following factors:
(a) Past and prospective loss experience within and outside this state.
(b) The past and prospective expenses.
(c) The degree of competition among insurers for the risk insured.
(d) Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. Such investment income shall not include income from invested surplus. The commission may adopt rules utilizing reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to motor vehicle insurance policies written in this state and the manner in which such investment income is used in the calculation of insurance rates. Such manner shall contemplate the use of a positive underwriting profit allowance in the rates that will be compatible with a reasonable rate of return plus provisions for contingencies. The total of the profit and contingency factor as specified in the filing shall be utilized in computing excess profits in conjunction with s. 627.066. In adopting such rules, the commission shall in all instances adhere to and implement the provisions of this paragraph.
(e) The reasonableness of the judgment reflected in the filing.
(f) Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.
(g) The cost of repairs to motor vehicles.
(h) The cost of medical services, if applicable.
(i) The adequacy of loss reserves.
(j) The cost of reinsurance.
(k) Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

(l) Other relevant factors which impact upon the frequency or severity of claims or upon expenses.
(3) Rates shall be deemed excessive if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.
(4) Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, when such replenishment is attributable to investment losses.
(5)(a) Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.
(b) The office has the responsibility to ensure that rates for private passenger vehicle insurance are adequate. To that end, the commission shall adopt rules establishing standards defining inadequate rates on private passenger vehicle insurance as defined in s. 627.041(8). In the event that the office finds that a rate or rate change is inadequate, the office shall order that a new rate or rate schedule be thereafter filed by the insurer and shall further provide information as to the manner in which noncompliance of the standards may be corrected. When a violation of this provision occurs, the office shall impose an administrative fine pursuant to s. 624.4211.
(6) One rate shall be deemed unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the difference in expected losses and expenses.
(7) Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long as rates reflect the differences with reasonable accuracy.
(8) Rates are not unfairly discriminatory if averaged broadly among members of a group; nor are rates unfairly discriminatory even though they are lower than rates for nonmembers of the group. However, such rates are unfairly discriminatory if they are not actuarially measurable and credible and sufficiently related to actual or expected loss and expense experience of the group so as to assure that nonmembers of the group are not unfairly discriminated against. Use of a single United States Postal Service zip code as a rating territory shall be deemed unfairly discriminatory unless filed pursuant to paragraph (1)(a) and the justification for its rate incorporates sufficient actual or expected loss and loss adjustment expense experience so as to be actuarially sound. The office shall require that any rate filing resulting from the use of a single zip code as a rating territory does not contain a rate or rate change that is excessive, inadequate, or unfairly discriminatory.
(9) In reviewing the rate or rate change filed, the office may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated herein.
(10) The office may, at any time, review a rate or rate change, the pertinent records of the insurer, and market conditions; and, if the office finds on a preliminary basis that the rate or rate change may be excessive, inadequate, or unfairly discriminatory, the office shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for a period of 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the office all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the

office withdraws the notification, the insurer shall not increase the rate until the earlier of 120 days after the date the notification was provided or 180 days after the date of the implementation of the rate. The office may, subject to chapter 120, disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(11) In the event the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule which responds to the findings of the office be filed by the insurer. The office shall further order for any "use and file" filing made in accordance with paragraph (1)(b), that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to such policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding shall be applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(12) Any portion of a judgment entered as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer shall not be included in the insurer's rate base, and shall not be used to justify a rate or rate change. Any portion of a settlement entered as a result of a statutory or common-law bad faith action identified as such and any portion of a settlement wherein an insurer agrees to pay specific punitive damages shall not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages in these judgments and settlements shall not be included in the insurer's rate base and shall not be utilized to justify a rate or rate change.

(13)(a) Underwriting rules not contained in rating manuals shall be filed for private passenger automobile insurance and homeowners insurance.

(b) The submission of rates, rating schedules, and rating manuals to the office by a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this subsection for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the rates, rating schedules, and rating manuals of such organization. All such information shall be available for public inspection, upon receipt by the office, during usual business hours.

(14)(a) Commercial motor vehicle insurance is not subject to subsection (1), subsection (2), or subsection (9) or s. 627.0645.

(b) The rates for insurance described in this subsection may not be excessive, inadequate, or unfairly discriminatory.

(c) Insurers shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on commercial motor vehicle insurance written in this state.

(d) An insurer must notify the office of any changes to rates for type of insurance described in this subsection no later than 30 days after the effective date of the change. The notice shall include the name of the insurer, the type or kind of insurance subject to rate change, and the average statewide percentage change in rates. Actuarial data with regard to rates for risks described in this subsection shall be maintained by the insurer for 2 years after the effective date of changes to those rates and are subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the factors in paragraphs (2)(a)-(l) and apply subsections (3)-(8) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

(e) A rating organization must notify the office of any changes to loss cost for the type of insurance described in this subsection no later than 30 days after the effective date of the change. The notice shall include the name of the rating organization, the type or kind of

insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to subsection (1), subsection (2), or subsection (9) shall be maintained by the rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the rate factors in paragraphs (2)(a)-(l) and apply subsections (3)-(8) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

627.072 Making and use of rates.—
(1) As to workers' compensation and employer's liability insurance, the following factors shall be used in the determination and fixing of rates:
(a) The past loss experience and prospective loss experience within and outside this state;
(b) The conflagration and catastrophe hazards;
(c) A reasonable margin for underwriting profit and contingencies;
(d) Dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;
(e) Investment income on unearned premium reserves and loss reserves;
(f) Past expenses and prospective expenses, both those countrywide and those specifically applicable to this state; and
(g) All other relevant factors, including judgment factors, within and outside this state.
(2) A retrospective rating plan may contain a provision that allows for negotiation of a premium between the employer and the insurer for employers having exposure in more than one state and an estimated annual standard premium in this state of $100,000 or more and an estimated annual countrywide standard premium of $750,000 or more for workers' compensation. Provisions within a retrospective rating plan authorizing negotiated premiums are exempt from subsection (1). Such plans and associated forms must be filed by a rating organization and approved by the office. However, a premium negotiated between the employer and the insurer pursuant to an approved retrospective rating plan is not subject to this part. Only insurers having at least $500 million in surplus as to policyholders may engage in the negotiation of premiums with eligible employers.
(3) As to all rates which are subject to this part, the systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.
(4) As to all rates which are subject to this part, risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that can be demonstrated to have a probable effect upon losses or expenses. Such classifications and modifications shall apply to all risks under the same or substantially the same circumstances or conditions.
(5)(a) In the case of workers' compensation and employer's liability insurance, the office shall consider utilizing the following methodology in rate determinations: Premiums, expenses, and expected claim costs would be discounted to a common point of time, such as the initial point of a policy year, in the determination of rates; the cash-flow pattern of premiums, expenses, and claim costs would be determined initially by using data from 8 to

10 of the largest insurers writing workers' compensation insurance in the state; such insurers may be selected for their statistical ability to report the data on an accident-year basis and in accordance with subparagraphs (b)1., 2., and 3., for at least 21/2 years; such a cash-flow pattern would be modified when necessary in accordance with the data and whenever a radical change in the payout pattern is expected in the policy year under consideration.
(b) If the methodology set forth in paragraph (a) is utilized, to facilitate the determination of such a cash-flow pattern methodology:
1. Each insurer shall include in its statistical reporting to the rating bureau and the office the accident year by calendar quarter data for paid-claim costs;
2. Each insurer shall submit financial reports to the rating bureau and the office which shall include total incurred claim amounts and paid-claim amounts by policy year and by injury types as of December 31 of each calendar year; and
3. Each insurer shall submit to the rating bureau and the office paid-premium data on an individual risk basis in which risks are to be subdivided by premium size as follows:

Number of Risks in Premium Range	Standard Premium Size
(to be filled in by carrier)	$300—999
(to be filled in by carrier)	1,000—4,999
(to be filled in by carrier)	5,000—49,999
(to be filled in by carrier)	50,000—99,999
(to be filled in by carrier)	100,000 or more

Total:

627.151 Basis of approval or disapproval of workers' compensation or employer's liability insurance filing; scope of disapproval power.—
(1) In determining at any time whether to approve or disapprove a filing as to workers' compensation or employer's liability insurance, or to permit the filing otherwise to become effective, the office shall give consideration only to the applicable standards and factors referred to in ss. 627.062 and 627.072.
(2) As to workers' compensation and employer's liability insurances, no manual of classifications, rule, rating plan, rating system, plan of operation, or any modification of any of the foregoing which establishes standards for measuring variations in hazards or expense provisions, or both, shall be disapproved if the rates thereby produced meet the applicable requirements of this part.

M E M O R A N D U M

DATE: May 30, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy VC
Stephen Fredrickson SF

SUBJECT: Cabinet Agenda for June 14, 2017
Request for Approval to Publish Repeal of
Rules 69O-136.002,.006
Assignment # 208610-17

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before June 7, 2017 and to the Financial Services Commission on June 14, 2017, with a request to approve for publication the proposed rules.

These two rules adopt various forms used for issuing Certificates of Authority to insurers. Rule Chapter 136 is being streamlined to eliminate duplication and also being updated to provide for electronic filing and adoption of forms which are currently in use by the Office. These two rules are being repealed as part of the reorganization and streamlining of the rule chapter.

Sections 624.308,624.307(1), 624.34, 624.401, 624.404, 624.407, 624.413, 624.422, 624.501, 626.7451(11), 628.161, 628.907, F.S., provide rulemaking authority and laws implemented for these rules.

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

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

69O-136.002 Foreign and Alien Insurers Filing for a Certificate of Authority.

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.34, 624.401, 624.404, 624.407, 624.413, 624.422, 624.501, 626.7451(11), 628.161, 628.907 FS. History–New 2-26-92, Amended 9-19-00, 11-18-02, Formerly 4-136.002, Repealed _____.

69O-136.006 Domestic Insurers Filing for an Application for Permit.

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.34, 624.401, 624.404, 624.407, 624.413, 624.422, 624.501, 626.7451(11), 628.051 FS. History–New 2-26-92, Amended 9-19-00, 11-18-02, Formerly 4-136.006 Repealed .

69O-136.002,.006

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

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

624.34 Authority of Department of Law Enforcement to accept fingerprints of, and exchange criminal history records with respect to, certain persons.—
(1) The Department of Law Enforcement may accept fingerprints of organizers, incorporators, subscribers, officers, stockholders, directors, or any other persons involved, directly or indirectly, in the organization, operation, or management of:
(a) Any insurer or proposed insurer transacting or proposing to transact insurance in this state.
(b) Any other entity which is examined or investigated or which is eligible to be examined or investigated under the provisions of the Florida Insurance Code.
(2) The Department of Law Enforcement may accept fingerprints of individuals who apply for a license as an agent, customer representative, adjuster, service representative, navigator, or managing general agent or the fingerprints of the majority owner, sole proprietor, partners, officers, and directors of a corporation or other legal entity that applies for licensure with the department or office under the Florida Insurance Code.
(3) The Department of Law Enforcement may, to the extent provided for by federal law, exchange state, multistate, and federal criminal history records with the department or office for the purpose of the issuance, denial, suspension, or revocation of a certificate of authority, certification, or license to operate in this state.
(4) The Department of Law Enforcement may accept fingerprints of any other person required by statute or rule to submit fingerprints to the department or office or any applicant or licensee regulated by the department or office who is required to demonstrate that he or she has not been convicted of or pled guilty or nolo contendere to a felony or a misdemeanor.
(5) The Department of Law Enforcement shall, upon receipt of fingerprints from the department or office, submit the fingerprints to the Federal Bureau of Investigation to check federal criminal history records.
(6) Statewide criminal records obtained through the Department of Law Enforcement, federal criminal records obtained through the Federal Bureau of Investigation, and local criminal records obtained through local law enforcement agencies shall be used by the department and office for the purpose of issuance, denial, suspension, or revocation of certificates of authority, certifications, or licenses issued to operate in this state.

624.401 Certificate of authority required.—
(1) No person shall act as an insurer, and no insurer or its agents, attorneys, subscribers, or representatives shall directly or indirectly transact insurance, in this state except as authorized by a subsisting certificate of authority issued to the insurer by the office, except as to such transactions as are expressly otherwise provided for in this code.

(2) No insurer shall from offices or by personnel or facilities located in this state solicit insurance applications or otherwise transact insurance in another state or country unless it holds a subsisting certificate of authority issued to it by the office authorizing it to transact the same kind or kinds of insurance in this state.
(3) This state hereby preempts the field of regulating insurers and their agents and representatives; and no county, city, municipality, district, school district, or political subdivision shall require of any insurer, agent, or representative regulated under this code any authorization, permit, or registration of any kind for conducting transactions lawful under the authority granted by the state under this code.
(4)(a) Any person who acts as an insurer, transacts insurance, or otherwise engages in insurance activities in this state without a certificate of authority in violation of this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(b) However, any person acting as an insurer without a valid certificate of authority who violates this section commits insurance fraud, punishable as provided in this paragraph. If the amount of any insurance premium collected with respect to any violation of this section:
1. Is less than $20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, and the offender shall be sentenced to a minimum term of imprisonment of 1 year.
2. Is $20,000 or more, but less than $100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, and the offender shall be sentenced to a minimum term of imprisonment of 18 months.
3. Is $100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, and the offender shall be sentenced to a minimum term of imprisonment of 2 years.

624.404 General eligibility of insurers for certificate of authority.—To qualify for and hold authority to transact insurance in this state, an insurer must be otherwise in compliance with this code and with its charter powers and must be an incorporated stock insurer, an incorporated mutual insurer, or a reciprocal insurer, of the same general type as may be formed as a domestic insurer under this code; except that:
(1) No insurer shall be authorized to transact insurance in this state which does not maintain reserves as required by part I of chapter 625 applicable to the kind or kinds of insurance transacted by such insurer, wherever transacted in the United States, or which transacts insurance in the United States on the assessment premium plan, stipulated premium plan, cooperative plan, or any similar plan.
(2) No foreign or alien insurer or exchange shall be authorized to transact insurance in this state unless it is otherwise qualified therefor under this code and has operated satisfactorily for at least 3 years in its state or country of domicile; however, the office may waive the 3-year requirement if the foreign or alien insurer or exchange:
(a) Has operated successfully and has capital and surplus of $5 million;
(b) Is the wholly owned subsidiary of an insurer which is an authorized insurer in this state;
(c) Is the successor in interest through merger or consolidation of an authorized insurer; or
(d) Provides a product or service not readily available to the consumers of this state.
(3)(a) The office shall not grant or continue authority to transact insurance in this state as to any insurer the management, officers, or directors of which are found by it to be incompetent or untrustworthy; or so lacking in insurance company managerial experience as to make the proposed operation hazardous to the insurance-buying public; or so lacking in insurance experience, ability, and standing as to jeopardize the reasonable promise of successful operation; or which it has good reason to believe are affiliated directly or indirectly through ownership, control, reinsurance transactions, or other insurance or

business relations, with any person or persons whose business operations are or have been marked, to the detriment of policyholders or stockholders or investors or creditors or of the public, by manipulation of assets, accounts, or reinsurance or by bad faith.
(b) The office shall not grant or continue authority to transact insurance in this state as to any insurer if any person, including any subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the insurer, or who influences or has the ability to influence the transaction of the business of the insurer, does not possess the financial standing and business experience for the successful operation of the insurer.
(c) The office may deny, suspend, or revoke the authority to transact insurance in this state of any insurer if any person, including any subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the insurer, or who influences or has the ability to influence the transaction of the business of the insurer, has been found guilty of, or has pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of 1 year or more under the law of the United States or any state thereof or under the law of any other country which involves moral turpitude, without regard to whether a judgment of conviction has been entered by the court having jurisdiction in such case. However, in the case of an insurer operating under a subsisting certificate of authority, the insurer shall remove any such person immediately upon discovery of the conditions set forth in this paragraph when applicable to such person or upon the order of the office, and the failure to so act by said insurer shall be grounds for revocation or suspension of the insurer's certificate of authority.
(d) The office may deny, suspend, or revoke the authority of an insurer to transact insurance in this state if any person, including any subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the insurer, or who influences or has the ability to influence the transaction of the business of the insurer, which person the office has good reason to believe is now or was in the past affiliated directly or indirectly, through ownership interest of 10 percent or more, control, or reinsurance transactions, with any business, corporation, or other entity that has been found guilty of or has pleaded guilty or nolo contendere to any felony or crime punishable by imprisonment for 1 year or more under the laws of the United States, any state, or any other country, regardless of adjudication. However, in the case of an insurer operating under a subsisting certificate of authority, the insurer shall immediately remove such person or immediately notify the office of such person upon discovery of the conditions set forth in this paragraph, either when applicable to such person or upon order of the office; the failure to remove such person, provide such notice, or comply with such order constitutes grounds for suspension or revocation of the insurer's certificate of authority.
(4)(a) No authorized insurer shall act as a fronting company for any unauthorized insurer which is not an approved reinsurer.
(b) A "fronting company" is an authorized insurer which by reinsurance or otherwise generally transfers more than 50 percent to one unauthorized insurer which does not meet the requirements of s. 624.610(3)(a), (b), or (c), or more than 75 percent to two or more unauthorized insurers which do not meet the requirements of s. 624.610(3)(a), (b), or (c), of the entire risk of loss on all of the insurance written by it in this state, or on one or more lines of insurance, on all of the business produced through one or more agents or agencies, or on all of the business from a designated geographical territory, without obtaining the prior approval of the office.
(c) The office may, in its discretion, approve a transfer of risk in excess of the limits in paragraph (b) upon presentation of evidence, satisfactory to the office, that the transfer would be in the best interests of the financial condition of the insurer and in the best interests of the policyholders.
(5) No insurer shall be authorized to transact insurance in this state which, during the 3 years immediately preceding its application for a certificate of authority, has violated any of the insurance laws of this state and after being informed of such violation has failed to

correct the same; except that, if all other requirements are met, the office may nevertheless issue a certificate of authority to such an insurer upon the filing by the insurer of a sworn statement of all such insurance so written in violation of law, and upon payment to the office of a sum of money as additional filing fee equivalent to all premium taxes and other state taxes and fees as would have been payable by the insurer if such insurance had been lawfully written by an authorized insurer under the laws of this state. This fee, when collected, shall be deposited to the credit of the Insurance Regulatory Trust Fund.
(6) Nothing in this code shall be deemed to prohibit the granting and continuance of a certificate of authority to a domestic title insurer organized as a business trust, if the declaration of trust of such insurer was filed in the office of the Secretary of State prior to January 1, 1959, and if the insurer otherwise meets the applicable requirements of this code. Such an insurer may hereinafter in this code be referred to as a "business trust insurer."
(7) For the purpose of satisfying the requirements of ss. 624.407 and 624.408, the investment portfolio of an insurer applying for an initial certificate of authority to do business in this state shall value its bonds and stocks in accordance with the provisions of the latest edition of the publication "Purposes and Procedures Manual of the NAIC Securities Valuation Office" by the National Association of Insurance Commissioners, July 1, 2002, and subsequent amendments thereto, if the valuation methodology remains substantially unchanged.

624.407 Surplus required; new insurers.—
(1) To receive authority to transact any one kind or combinations of kinds of insurance, as defined in part V of this chapter, an insurer applying for its original certificate of authority in this state shall possess surplus as to policyholders at least the greater of:
(a) For a property and casualty insurer, $5 million, or $2.5 million for any other insurer;
(b) For life insurers, 4 percent of the insurer's total liabilities;
(c) For life and health insurers, 4 percent of the insurer's total liabilities, plus 6 percent of the insurer's liabilities relative to health insurance;
(d) For all insurers other than life insurers and life and health insurers, 10 percent of the insurer's total liabilities;
(e) Notwithstanding paragraph (a) or paragraph (d), for a domestic insurer that transacts residential property insurance and is:
1. Not a wholly owned subsidiary of an insurer domiciled in any other state, $15 million.
2. A wholly owned subsidiary of an insurer domiciled in any other state, $50 million; or
(f) Notwithstanding paragraphs (a), (d), and (e), for a domestic insurer that only transacts limited sinkhole coverage insurance for personal lines residential property pursuant to s. 627.7151, $7.5 million.
(2) Notwithstanding subsection (1), a new insurer may not be required to have surplus as to policyholders greater than $100 million.
(3) The requirements of this section shall be based upon all the kinds of insurance actually transacted or to be transacted by the insurer in any and all areas in which it operates, whether or not only a portion of such kinds of insurance are transacted in this state.
(4) As to surplus as to policyholders required for qualification to transact one or more kinds of insurance, domestic mutual insurers are governed by chapter 628, and domestic reciprocal insurers are governed by chapter 629.
(5) For the purposes of this section, liabilities do not include liabilities required under s. 625.041(5). For purposes of computing minimum surplus as to policyholders pursuant to s. 625.305(1), liabilities include liabilities required under s. 625.041(5).

624.413 Application for certificate of authority.—

(1) To apply for a certificate of authority, an insurer shall file its application therefor with the office, upon a form adopted by the commission and furnished by the office, showing its name; location of its home office and, if an alien insurer, its principal office in the United States; kinds of insurance to be transacted; state or country of domicile; and such additional information as the commission reasonably requires, together with the following documents:

(a) One copy of its corporate charter, articles of incorporation, existing and proposed nonfacultative reinsurance contracts, declaration of trust, or other charter documents, with all amendments thereto, certified by the public official with whom the originals are on file in the state or country of domicile.

(b) If a mutual insurer, a copy of its bylaws, as amended, certified by its secretary or other officer having custody thereof.

(c) If a foreign or alien reciprocal insurer, a copy of the power of attorney of its attorney in fact and of its subscribers' agreement, if any, certified by the attorney in fact; and, if a domestic reciprocal insurer, the declaration provided for in s. 629.081.

(d) A copy of its financial statement as of December 31 next preceding, containing information generally included in insurer financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally utilized by insurers for financial statements, sworn to by at least two executive officers of the insurer, or certified by the public official having supervision of insurance in the insurer's state of domicile or of entry into the United States. To facilitate uniformity in financial statements, the commission may by rule adopt the form for financial statements approved by the National Association of Insurance Commissioners in 2002, and may adopt subsequent amendments thereto if the form remains substantially consistent.

(e) Supplemental quarterly financial statements for each calendar quarter since the beginning of the year of its application for the certificate of authority, sworn to by at least two of its executive officers. To facilitate uniformity in financial statements, the commission may by rule adopt the form for quarterly financial statements approved by the National Association of Insurance Commissioners in 2002, and may adopt subsequent amendments thereto if the form remains substantially consistent.

(f) If a foreign or alien insurer, a copy of the report of the most recent examination of the insurer certified by the public official having supervision of insurance in its state of domicile or of entry into the United States. The end of the most recent year covered by the examination must be within the 5-year period preceding the date of application. In lieu of the certified examination report, the office may accept an audited certified public accountant's report prepared on a basis consistent with the insurance laws of the insurer's state of domicile, certified by the public official having supervision of insurance in its state of domicile or of entry into the United States.

(g) If a foreign or alien insurer, a certificate of compliance from the public official having supervision of insurance in its state or country of domicile showing that it is duly organized and authorized to transact insurance therein and the kinds of insurance it is so authorized to transact.

(h) If a foreign or alien insurer, a certificate of the public official having custody of any deposit maintained by the insurer in another state in lieu of a deposit or part thereof required in this state under s. 624.411 or s. 624.412, showing the amount of such deposit and the assets or securities of which comprised.

(i) If a life insurer, a certificate of valuation.

(j) If an alien insurer, a copy of the appointment and authority of its United States manager, certified by its officer having custody of its records.

(2) The application shall be accompanied by the applicable fees and license tax as specified in s. 624.501.

624.422 Service of process; appointment of Chief Financial Officer as process agent.—

(1) Each licensed insurer, whether domestic, foreign, or alien, shall be deemed to have appointed the Chief Financial Officer and her or his successors in office as its attorney to receive service of all legal process issued against it in any civil action or proceeding in this state; and process so served shall be valid and binding upon the insurer.
(2) Prior to its authorization to transact insurance in this state, each insurer shall file with the department designation of the name and address of the person to whom process against it served upon the Chief Financial Officer is to be forwarded. The insurer may change the designation at any time by a new filing.
(3) Service of process upon the Chief Financial Officer as the insurer's attorney pursuant to such an appointment shall be the sole method of service of process upon an authorized domestic, foreign, or alien insurer in this state.

624.501 Filing, license, appointment, and miscellaneous fees.—The department, commission, or office, as appropriate, shall collect in advance, and persons so served shall pay to it in advance, fees, licenses, and miscellaneous charges as follows:
(1) Certificate of authority of insurer.
(a) Filing application for original certificate of authority or modification thereof as a result of a merger, acquisition, or change of controlling interest due to a sale or exchange of stock, including all documents required to be filed therewith, filing fee.....$1,500.00
(b) Reinstatement fee.....$50.00
(2) Charter documents of insurer.
(a) Filing articles of incorporation or other charter documents, other than at time of application for original certificate of authority, filing fee.....$10.00
(b) Filing amendment to articles of incorporation or charter, other than at time of application for original certificate of authority, filing fee.....$5.00
(c) Filing bylaws, when required, or amendments thereof, filing fee.....$5.00
(3) Annual license tax of insurer, each domestic insurer, foreign insurer, and alien insurer (except that, as to fraternal benefit societies insuring less than 200 members in this state and the members of which as a prerequisite to membership possess a physical handicap or disability, such license tax shall
be $25).....$1,000.00
(4) Statements of insurer, filing (except when filed as part of application for original certificate of authority), filing fees:
(a) Annual statement.....$250.00
(b) Quarterly statement.....$250.00
(5) All insurance representatives, application for license, application for reinstatement of suspended license, each filing, filing fee.....$50.00
(6) Insurance representatives, property, marine, casualty, and surety insurance.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or unaffiliated agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Customer representative's original appointment and biennial renewal or continuation thereof:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(c) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer or unaffiliated agent making an appointment.....$60.00
(d) Service representatives; managing general agents.

Original appointment and biennial renewal or continuation thereof, each insurer or managing general agent, whichever is applicable.....$60.00

(7) Life insurance agents.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or unaffiliated agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer or unaffiliated agent making an appointment.....$60.00
(8) Health insurance agents.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or unaffiliated agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer or unaffiliated agent making an appointment.....$60.00
(9)(a) Except as provided in paragraph (b), all limited appointments as agent, as provided for in s. 626.321. Agent's original appointment and biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) For all limited appointments as agent, as provided in s. 626.321(1)(c) and (d), the agent's original appointment and biennial renewal or continuation thereof for each insurer is equal to the number of offices, branch offices, or places of business covered by the license multiplied by the fees set forth in paragraph (a).
(10) Fraternal benefit society agents. Original appointment and biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(11) Surplus lines agent. Agent's appointment and biennial renewal or continuation thereof, appointment fee.....$150.00
(12) Adjusters:
(a) Adjuster's original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(b) Nonresident adjuster's original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(c) Emergency adjuster's license, appointment fee.....$10.00
(d) Fee to cover actual cost of credit report, when such report must be secured by department.
(13) Examination—Fee to cover actual cost of examination.
(14) Temporary license and appointment as agent or adjuster, where expressly provided for, rate of fee for each month of the period for which the license and appointment is issued.....$5.00
(15) Issuance, reissuance, reinstatement, modification resulting in a modified license being issued, duplicate copy of any insurance representative license, or an appointment being reinstated.....$5.00
(16) Additional appointment continuation fees as prescribed in chapter 626.....$5.00
(17) Filing application for permit to form insurer as referred to in chapter 628, filing fee.....$25.00
(18) Annual license fee of rating organization, each domestic or foreign organization.....$25.00
(19) Miscellaneous services:
(a) For copies of documents or records on file with the department, commission, or office, per
page.....$ .15
(b) For each certificate of the department, commission, or office under its seal, authenticating any document or other instrument (other than a license or certificate of authority).....$5.00
(c) For preparing lists of agents, adjusters, and other insurance representatives, and for other miscellaneous services, such reasonable charge as may be fixed by the office or department.

(d) For processing requests for approval of continuing education courses, processing fee.....$100.00
(e) Insurer's registration fee for agent exchanging business more than 24 times in calendar year under s. 626.752, s. 626.793, or s. 626.837, registration fee per agent per year.....$30.00
(20) Adjusting firm, original or renewal 3-year license.....$60.00
(21) Limited surety agent or professional bail bond agent, as defined in s. 648.25, each agent and each insurer represented. Original appointment and biennial renewal or continuation thereof, each agent or insurer, whichever is applicable:

Appointment fee.....$44.00

State tax.....24.00

County tax.....12.00

Total.....$80.00

(22) Certain military installations, as authorized under s. 626.322: original appointment and biennial renewal or continuation thereof, each insurer.....$20.00
(23) Filing application for original certificate of authority for third-party administrator or original certificate of approval for a service company, including all documents required to be filed therewith, filing fee.....$100.00
(24) Fingerprinting processing fee—Fee to cover fingerprint processing.
(25) Sales representatives, miscellaneous lines. Original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(26) Reinsurance intermediary:
(a) Application filing and license fee.....$50.00
(b) Original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(27) Title insurance agents:
(a) Agent's original appointment or biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Agency original appointment or biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(c) Filing for title insurance agent's license:

Application for filing, each filing, filing fee.....$10.00

(d) Additional appointment continuation fee as prescribed by s. 626.843.....$5.00
(e) Title insurer and title insurance agency administrative surcharge:
1. On or before January 30 of each calendar year, each title insurer shall pay to the office for each licensed title insurance agency appointed by the title insurer and for each retail office of the insurer on January 1 of that calendar year an administrative surcharge of $200.00.
2. On or before January 30 of each calendar year, each licensed title insurance agency shall remit to the department an administrative surcharge of $200.00.

The administrative surcharge may be used solely to defray the costs to the department and office in their examination or audit of title insurance agencies and retail offices of title insurers and to gather title insurance data for statistical purposes to be furnished to and used by the office in its regulation of title insurance.

(28) Late filing of appointment renewals for agents, adjusters, and other insurance representatives, each appointment.....$20.00

626.7451 Managing general agents; required contract provisions.—No person acting in the capacity of a managing general agent shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibility for a particular function, specifies the division of responsibilities, and contains the following minimum provisions:

(11) A licensed managing general agent, when placing business with an insurer under this code, may charge a per-policy fee not to exceed $25. In no instance shall the aggregate of per-policy fees for a placement of business authorized under this section, when combined with any other per-policy fee charged by the insurer, result in per-policy fees which exceed the aggregate amount of $25. The per-policy fee shall be a component of the insurer's rate filing and shall be fully earned.

628.051 Application for permit to form insurer; contents; fee.—
(1) No domestic insurer shall be formed unless the persons so proposing have received a permit from the office.
(2) Written application for such permit shall be filed with the office. Such application and filing shall include:
(a) The name, type, and purpose of insurer.
(b) The name, residence address, business background, and qualifications of each person associated or to be associated in the formation or financing of the insurer. Each such person with an ownership interest of 10 percent or more, or who will hold a position as an officer or director, must furnish on forms adopted by the commission and supplied by the office a sworn biographical statement, legible copies of fingerprints, and authority for release of information in regard to the investigation of such person's background.
(c) A full disclosure of the terms of all understandings and agreements existing or proposed among persons so associated relative to the insurer, or the formation or financing thereof, accompanied by a copy of each such agreement or understanding.

(d) A full disclosure of the terms of all understandings and agreements existing or proposed for management or exclusive agency contracts.
(e) A copy of all proposed articles or certificates of incorporation and proposed bylaws of the proposed insurer.
(f) A copy of all articles or certificates of incorporation of involved corporations, if a copy of the same is not already on file in the office.
(g) A copy of all syndicate, association, firm, partnership, organization, or other similar agreements, by whatever name called, involved in the formation of the proposed insurer or its financing.
(h) If the applicant is a reciprocal insurer, a copy of the power of attorney and of other agreements existing or proposed as affecting investors, subscribers, the attorney in fact, or the applicant.
(i) A copy of any security, or of any proposed document evidencing any right or interest, proposed to be offered.
(j) Such other pertinent information and documents as reasonably requested by the commission or office.
(3) The application shall be accompanied by the filing fee specified in s. 624.501.

628.161 Initial qualifications; mutuals.—
(1) When newly organized, a mutual insurer may be authorized to transact any of the kinds of insurance listed in the schedule contained in subsection (2).
(2)(a) When applying for an initial certificate of authority, the mutual insurer must have unencumbered surplus as to policyholder funds in the amount set out below as minimum initial surplus as to policyholders:
1. With respect to health insurance, $300,000.
2. With respect to property insurance, $200,000.
3. With respect to casualty insurance, $300,000.
4. With respect to any combination of health, property, or casualty insurance, $400,000.
5. With respect to life insurance, $2.5 million.
(b) Thereafter, the mutual insurer must maintain the maintenance level surplus as to policyholders set out below:
1. With respect to health insurance, $200,000.
2. With respect to property insurance, $150,000.
3. With respect to casualty insurance, $200,000.
4. With respect to any combination of health, property, or casualty insurance, $250,000.
5. With respect to life insurance, $1.5 million.
(3) The mutual insurer shall make an initial deposit with the department and thereafter maintain such deposit in an amount equal to one-half the minimum initial surplus as required in paragraph (2)(a), except that with respect to life insurance, the deposit shall be in the amount of $200,000.
(4) Unless a mutual insurer maintains the minimum surplus as to policyholders required by s. 624.408, the mutual insurer must be organized as an assessable mutual insurer subject to the requirements of part II of this chapter.
(5) Deposits required by this section shall be made in compliance with part III of chapter 625. This deposit requirement is in lieu of the requirements of s. 624.411.
(6) A self-insured fund organized under s. 624.4621 and holding a certificate of authority as a self-insurer's fund on December 31, 1993, may become a mutual insurer under this part, pursuant to a plan of reorganization approved by the office. A plan of reorganization must be approved by the office if:
(a) The self-insurer's fund has sufficient financial resources to satisfy all of its obligations under all policies and coverages afforded by the fund before the reorganization and has sufficient financial resources to satisfy all of its other liabilities;
(b) The self-insurer's fund has a minimum of $5 million of surplus;

(c) The self-insurer's fund submits a plan that demonstrates its ability to satisfy the requirements of this chapter pertaining to mutual insurers on an ongoing basis; and
(d) The mutual insurer resulting from the reorganization of the self-insurer's fund retains ownership of all of the assets of the self-insurer's fund, retains all of the liabilities of the self-insurer's fund, and agrees to hold all fund members harmless from any assessment for liabilities of the self-insurer's fund before the date of reorganization.
Upon approval of the plan by the office, any contingent liability of the members or former members of the self-insurer's fund for assessment for losses of the self-insurer's fund is considered satisfied, and all liability for any such contingent assessment is extinguished as of the date the self-insurer's fund becomes an authorized mutual insurer and retains all of the assets and liabilities of the self-insurer's fund.

628.907 Minimum capital and net assets requirements; restriction on payment of dividends.—
(1) A captive insurance company may not be issued a license unless it possesses and thereafter maintains unimpaired paid-in capital of:
(a) In the case of a pure captive insurance company, at least $100,000;
(b) In the case of an industrial insured captive insurance company incorporated as a stock insurer, at least $200,000; and
(c) In the case of a special purpose captive insurance company, an amount determined by the office after giving due consideration to the company's business plan, feasibility study, and pro forma financial statements and projections, including the nature of the risks to be insured.
(2) The office may not issue a license to a captive insurance company incorporated as a nonprofit corporation unless the company possesses and maintains unrestricted net assets of:
(a) In the case of a pure captive insurance company, at least $250,000.
(b) In the case of a special purpose captive insurance company, an amount determined by the office after giving due consideration to the company's business plan, feasibility study, and pro forma financial statements and projections, including the nature of the risks to be insured.
(3) Contributions to a captive insurance company incorporated as a nonprofit corporation must be in the form of cash, cash equivalent, or an irrevocable letter of credit issued by a bank chartered by this state or a member bank of the Federal Reserve System with a branch office in this state, or as approved by the office.
(4) For purposes of this section, the office may issue a license expressly conditioned upon the captive insurance company providing to the office satisfactory evidence of possession of the minimum required unimpaired paid-in capital. Until this evidence is provided, the captive insurance company may not issue any policy, assume any liability, or otherwise provide coverage. The office may revoke the conditional license if satisfactory evidence of the required capital is not provided within a maximum period of time, not to exceed 1 year, to be established by the office at the time the conditional license is issued.
(5) The office may prescribe additional capital or net assets based upon the type, volume, and nature of insurance business transacted. Contributions in connection with these prescribed additional net assets or capital must be in the form of:
(a) Cash;
(b) Cash equivalent;
(c) An irrevocable letter of credit issued by a bank chartered by this state or a member bank of the Federal Reserve System with a branch office in this state, or as approved by the office; or
(d) Securities invested as provided in part II of chapter 625.

(6) A captive insurance company may not pay a dividend out of, or other distribution with respect to, capital or surplus in excess of the limitations set forth in this chapter without the prior approval of the office. Approval of an ongoing plan for the payment of dividends or other distributions must be conditioned upon the retention, at the time of each payment, of capital or surplus in excess of amounts specified by, or determined in accordance with formulas approved by, the office.

(7) An irrevocable letter of credit that is issued by a financial institution other than a bank chartered by this state or a member bank of the Federal Reserve System must meet the same standards as an irrevocable letter of credit that has been issued by a bank chartered by this state or a member bank of the Federal Reserve System.

M E M O R A N D U M

DATE: May 22, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for June 14, 2017
Request for Approval to Publish Amendments to
Rules 69O-136.004,.005,.011,.012,.015,.018. 031,.032,.034
Assignment # 191465-16

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before June 7, 2017 and to the Financial Services Commission on June 14, 2017, with a request to approve for publication the proposed rules.

The purpose of this rule chapter revision is to streamline the application process, update forms to reflect current practice and to reflect that applications are made by the electronic filing process on the Office web site.

Sections 624.308, 627.954, 624.09, 624.307(1), 624.34, 624.402,624.407, 624.408, 624.411, 624.413, 624.414(1), 624.416(4), 624.422, 624.462, 624.466, 624.501, 624.610(11), 625.306, 626.913, 626.918, 628.041, 628.6011, 628.051, 628.061, 628.71, 628.081, 628.091, 628.121, 628.151, 628.161, 628.221, 628.231, 628.251, 628.261, 628.451, 628.461, 628.4615, 628.471, 628.905, 629.071, 629.081, 629.091, 629.101, 629.121, 629.131, 629.181 , F.S., provide rulemaking authority and laws implemented for these rules.

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

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

69O-136.004 Surplus Lines.

All insurers seeking eligibility as a Surplus Lines insurer ~~Applications submitted as an Insurer~~ under Florida's Surplus Lines Law, pursuant to Section 626.913, F.S., shall submit ~~contain all of~~ the following forms and requirements therein:

~~(1) Form OIR-C1-915, "Application as an Insurer Under Florida's Surplus Lines Law," rev. 12/97;~~

(1) ~~(2)~~ Form OIR-C1-916, "Application for Eligibility as a Surplus Lines Insurer", rev.5/17 ~~"Instructions, Sections I-IV," rev. 5/99~~;

~~(3) Form OIR-C1-917, "Required Filings Check List, Sections I-IV," rev. 5/98;~~

(2) ~~(4)~~ Form OIR-C1-1524 ~~OIR-C1-144~~, "Uniform Consent to Service of Process ~~Consent & Agreement~~," ~~rev. 1/97~~, as adopted in Rule 69O-143.056, F.A.C.;

~~(5) Form OIR-C1-903, "Invoice, Request for Payment of Fingerprint Charges," rev. 4/97;~~

(3) ~~(6)~~ Form OIR-C1-1416 ~~OIR-C1-877~~, "Uniform Certificate of Authority (UCAA) ~~Property and Casualty Insurers,~~ Lines of Insurance ~~Business by Company Code~~," as adopted in Rule 69O-143.056; F.A.C. ~~11/05/99~~;

(4) ~~(7)~~ Form OIR-C1-1423 ~~OIR-C1-422~~, "Biographical ~~Statement and~~ Affidavit", ~~rev. 10/26/98~~ as adopted in Rule 69O-143.056, F.A.C.;

~~(8) Form OIR-C1-450, "Authority for Release of Information," rev. 5/00;~~

(5) ~~(9)~~ An investigative report in accordance with the instructions on Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," as adopted in Rule 69O-143.056, F.A.C. ~~rev. 2/01~~;

(6) ~~(10)~~ Form OIR-C1-938, "Fingerprint Card Instructions," as adopted in Rule 69O-143.056, F.A.C. ~~rev. 7/99~~; and,

(7) ~~(11)~~ Form OIR-C1-1298, "Uniform Certificate of Authority Application (UCAA) - Management Information Form," as adopted in Rule 69O-143.056, F.A.C. ~~rev. 4/97~~.

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.34, 624.422, 624.501, 626.913, 626.918 FS. History–New 2-26-92, Amended 9-19-00, 11-18-02, Formerly 4-136.004, Amended _____.

69O-136.005 Captive Insurers.

All domestic captive insurers filing an a application for licensure, pursuant to Part V of Chapter 628, F.S., shall submit the following forms and requirments therein:

(1) Form OIR-C1-2114, "Application for Captive Insurer", rev. 5/17;

(2) Form OIR-C1-1416, "Uniform Certificate of Authority (UCAA) Lines of Insurance", as adopted in Rule 69O-143.056, F.A.C.;

(3) Form OIR-C1-1423, "Biographical Affidavit", as adopted in Rule 69O-143.056, F.A.C.;

(4) Form OIR-DO-896, "UCAA Proforma Financial Statements, Property and Casualty Insurance Company", as adopted in Rule 69O-143.056, F.A.C.;

(5) Form OIR-C1-1524, "Uniform Consent to Service of Process", as adopted in Rule 69O-143.056, F.A.C.;

(6) An investigative report in accordance with the instructions on Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," as adopted in Rule 69O-143.056, F.A.C.; and,

(7) Form OIR-C1-938, "Fingerprint Card Instructions," as adopted in Rule 69O-143.056, F.A.C.

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 628.905 FS. History–New _____, 2017. Formerly in 69O-136.006.

69O-136.011 Domestic Insurers Filing for a Permit or Preliminary Certificate of Authority, as applicable, and Certificate of Authority

(1) All domestic Property and Casualty, Title, Life, and Life and Health insurers applying for a permit, pursuant to Chapter 628, Part I, F.S., and certificate of authority pursuant to Chapter 624, F.S. and Chapter 628, Parts I and II, F.S., shall comply with the instructions for a Primary Application as contained in the Uniform Certificate of Authority Application (UCAA) Instructions and any other requirements specifically listed or referenced including submitting the following forms and requirements therein. Such filings shall not exempt a domestic insurer from any requirements under F.S.

(a) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) Instructions", rev. 12/16;

(b) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) - Primary Application Checklist", which includes Form OIR-C1-1298, "Uniform Certificate of Authority Application (UCAA) - Management Information Form," as adopted in Rule 69O-143.056, F.A.C.;

(c) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) - Primary Application";

(d) Form OIR-C1-1416, "Uniform Certificate of Authority (UCAA) Lines of Insurance", as adopted in Rule 69O-143.056, F.A.C.;

(e) Form OIR-C1-1422, "Uniform Certificate of Authority Application Questionnaire", as adopted in Rule 69O-136.034, F.A.C.;

(f) Form OIR-DO-896, "UCAA Proforma Financial Statements, Property and Casualty Insurance Company", as adopted in Rule 69O-143.056, F.A.C.;

(g) Form OIR-DO-896, "UCAA Proforma Financial Statements, Life & Health Insurer", as adopted in Rule 69O-143.056, F.A.C.;

(h) Form OIR-DO-896, "UCAA Proforma Financial Statements, Title Insurance Company", as adopted in Rule 69O-143.056, F.A.C.;

(i) Form OIR-DO-896, "UCAA Proforma Financial Statements, Health", as adopted in Rule 69O-143.056, F.A.C.;

(j) Form OIR-C1-1423, "Biographical Affidavit", as adopted in Rule 69O-143.056, F.A.C.;

(k) An investigative report in accordance with the instructions on Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," as adopted in Rule 69O-143.056, F.A.C.;

(l) Form OIR-D0-516, "Insurance Company System Registration Statement," as adopted in Rule 69O-143.056, F.A.C.;

(m) Form OIR-C1-1524, "Uniform Consent to Service of Process", as adopted in Rule 69O-143.056, F.A.C.;

(n) Form OIR-C1-1389, "NAIC Company Code Application Form," rev. 2/16; and

(o) Form OIR-C1-XXXX, "Primary Application, Florida Specific Information", which includes Form OIR-C1-

938, "Fingerprint Card Instructions", as adopted in Rule 69O-143.056, F.A.C.

~~All domestic entities seeking a certificate of authority, pursuant to Sections 624.466, 628.6011, or 628.051, or to Chapters 628, Part I, 629, F.S., shall submit the following forms:~~

~~(a) Form OIR-C1-903, "Invoice, Request for Payment of Fingerprint Charges," rev. 4/97;~~

~~(b) Form OIR-C1-883, "Certificate of Designation, Registered Agent/Registered Office," rev. 4/00;~~

~~(c) Form OIR-C1-144, "Services of Process Consent & Agreement," rev. 1/97;~~

~~(d) Form OIR-C1-516, "Insurance Holding Company System Registration Statement," rev. 4/97;~~

~~(e) Form OIR-C1-422, "Biographical Statement and Affidavit," rev. 10/26/98;~~

~~(f) Form OIR-C1-450, "Authority For Release of Information," rev. 5/00;~~

~~(g) An investigative report in accordance with the instructions on Form OIR-C1-905, "Instructions for Furnishing Background Investiagtive Reports," rev. 2/01;~~

~~(h) Form OIR-C1-938, "Fingerprint Card Instructions," rev. 7/99;~~

~~(i) Form OIR-C1-844, "Management Information Form," rev. 4/97;~~

~~(j) Form OIR-C1-878, "Application For Certificate of Authority Domestic Insurer," rev. 2/00;~~

~~(k) Form OIR-C1-1299, "Invoice Domestic Insurer Application for Certificate of Authority," rev. 4/97;~~

~~(l) Form OIR-C1-882, "Application For Domestic Certificate of Authority to Conduct Business in the State of Florida," rev. 4/97;~~

~~(m) Form OIR-C1-901, "Life, Accident and Health Insurers Lines of Business by Company Code," rev. 2/01;~~

~~(n) Form OIR-C1-877, "Property and Casualty Insurers Lines of Business by Company Code," rev. 11/05/99;~~

~~(o) Form OIR-C1-896, "Life, Accident, and Health Insurance Company Pro Formas (Pages 1-4)," rev. 11/98;~~

~~(p) Form OIR-C1-896, "Property & Casualty Insurance Company Pro Formas (Pages 5-22)," rev. 11/98;~~

~~(q) Form OIR-C1-1301, "Subscription Agreement Form," rev. 5/99; and,~~

~~(f) Form OIR-C1-1389, "NAIC Company Code Application Form," rev. 2/01.~~

(2) A ~~Applications submitted for Certificate of Authority as a~~ Commercial Self-Insurance Fund applying for a certificate of authority ~~shall contain all of the following forms~~ pursuant to Section 624.466 ~~624.462~~, F.S., shall submit the following forms and requirements therein:

(a) Form OIR-C1-845, "Application for Certificate of Authority, Commercial Self-Insurance Fund," rev. 5/17 ~~4/95~~;

(b) Form OIR-C1-1524, "Uniform Consent to Service of Process", as adopted in Rule 69O-143.056, F.A.C;

(c) Form OIR-C1-1298, "Uniform Certificate of Authority Application (UCAA) - Management Information Form," as adopted in Rule 69O-143.056, F.A.C.;

(d) Form OIR-C1-1416, "Uniform Certificate of Authority (UCAA) Lines of Insurance", as adopted in Rule 69O-143.056, F.A.C.;

(e) Form OIR-DO-896, "UCAA Proforma Financial Statements, Property and Casualty Insurance Company", as adopted in Rule 69O-143.056, F.A.C.;

(f) Form OIR-C1-1423, "Biographical Affidavit", as adopted in Rule 69O-143.056, F.A.C.;

(g) An investigative report in accordance with the instructions on Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," as adopted in Rule 69O-143.056, F.A.C.; and

(h) Form OIR-C1-938, "Fingerprint Card Instructions," as adopted in Rule 69O-143.056, F.A.C.

~~(b) Form OIR-C1-848, "Invoice, Commercial Self-Insurance Fund," rev. 7/92;~~

~~(c) Form OIR-C1-849, "Application for License to Conduct Business in the State of Florida," rev. 5/91;~~

~~(d) Form OIR-C1-869, "Consent and Agreement in Re Service of Process for Commercial Self-Insurance Fund," rev. 5/91;~~

~~(e) Form OIR-C1-870, "Resolution Form for Commercial Self-Insurance Fund," rev. 5/91;~~

~~(f) Form OIR-C1-871, "Bond Form," rev. 5/91;~~

~~(g) Form OIR-C1-936, "Management Information, Complete Listing of Administrators, Trustees of Funds and Trustees of Sponsors," rev. 5/91;~~

~~(h) Form OIR-C1-903, "Invoice, Request for Payment of Fingerprint Charges," rev. 4/97;~~

~~(i) Form OIR-C1-877, "Property and Casualty Insurers, Lines of Business by Company Code," rev. 11/05/99;~~

~~(j) Form OIR-C1-896, "Property & Casualty Insurance Company Pro Formas (Pages 5-22)," rev. 11/98;~~

~~(k) Form OIR-C1-422, "Biographical Statement and Affidavit," rev. 10/26/98;~~

~~(l) Form OIR-C1-450, "Authority for Release of Information," rev. 5/00;~~

~~(m) An investigative report in accordance with the instructions on Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," rev. 2/01; and,~~

~~(n) Form OIR-C1-938, "Fingerprint Card Instructions," rev. 7/99;~~

(3) A ~~Applications submitted for a Certificate of Authority of~~ Domestic Reciprocal Insurers~~,~~ applying for a certificate of authority pursuant to Chapter 629, F.S., shall submit the following forms and requirements therein:

(a) Form OIR-C1-908, "Application for Certificate of Authority Domestic Reciprocal Insurer," rev. 5/17;

(b) Form OIR-C1-1524, "Uniform Consent to Service of Process", as adopted in Rule 69O-143.056, F.A.C.

(c) Form OIR-C1-1298, "Uniform Certificate of Authority Application (UCAA) - Management Information Form," as adopted in Rule 69O-143.056, F.A.C., which lists all Attorney In Fact Officers, Directors and Shareholders;

(d) Form OIR-C1-1416, "Uniform Certificate of Authority (UCAA) Lines of Insurance", as adopted in Rule 69O-143.056, F.A.C.;

(e) Form OIR-DO-896, "UCAA Proforma Financial Statements, Property and Casualty Insurance Company", as adopted in Rule 69O-143.056, F.A.C.;

(f) Form OIR-C1-1423, "Biographical Affidavit", as adopted in Rule 69O-143.056, F.A.C.;

(g) Form OIR-C1-938, "Fingerprint Card Instructions", as adopted in Rule 69O-143.056, F.A.C.

(h) An investigative report in accordance with the instructions on Form OIR-C1-905, "Instructions for

Furnishing Background Investigative Reports," as adopted in Rule 69O-143.056, F.A.C.

(i) ~~(h)~~ Form OIR-C1-914, "Complete Listing of All Advisory Committee Members and Subscribers," rev. 5/91; and

(j) ~~(n)~~ Form OIR-C1-1389, "NAIC Company Code Application Form," rev. 2/16. ~~5/00~~

~~(a) Form OIR-C1-907, "Application for Certificate of Authority Domestic Reciprocal Insurer," rev. 4/95;~~

~~(b) Form OIR-C1-908, "Instructions, Sections I-IV," rev. 4/95;~~

~~(c) Form OIR-C1-909, "Required Filings Check List, Sections I-IV," rev. 4/95;~~

~~(d) Form OIR-C1-910, "Invoice, Domestic Reciprocal Insurer," rev. 7/92;~~

~~(e) Form OIR-C1-911, "Application for License to Conduct Business in the State of Florida," rev. 5/91;~~

~~(f) Form OIR-C1-912, "Consent and Agreement in re Service of Process, Reciprocal Insurers," rev. 5/91;~~

~~(g) Form OIR-C1-843, "Florida Comprehensive Health Association Subscription Agreement," rev. 5/91;~~

(i) Form OIR-C1-937, "Complete Listing of All Attorney-In-Fact Officers, Directors and Shareholders," rev. 5/91.

~~(j) Form OIR-C1-903, "Invoice, Request for Payment of Fingerprint Charges," rev. 4/97;~~

~~(k) Form OIR-C1-877, " Property And Casualty Insurers Lines of Business by Company Code," rev. 11/05/99;~~

~~(l) Form OIR-C1-913, "Resolution Form, Reciprocal Insurer," rev. 5/91;~~

~~(m) Form OIR-C1-896, Pages 5 - 22 for "Property & Casualty Insurers," rev. 11/98;~~

~~(o) Form OIR-C1-422, "Biographical Statement and Affidavit," rev. 10/26/98;~~

~~(p) Form OIR-C1-450, "Authority for Release of Information," rev. 5/00;~~

~~(q) Form OIR-C1-938, "Fingerprint Card Instructions," rev. 7/99; and,~~

~~(r) Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," rev. 0201.~~

(4) A Domestic Fraternal Benefit Society applying for a preliminary certificate of authority and subsequent

certificate of authority pursuant to Chapter 632, F.S., shall comply with the instructions for a Primary Application as contained in the Uniform Certificate of Authority Application (UCAA) Instructions and any other requirements specifically listed or referenced including submitting the following forms and requirements therein:

(a) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) Instructions" rev.12/16;

(b) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) – Primary Application Checklist", which includes Form OIR-C1-1298, "Uniform Certificate of Authority Application (UCAA) – Management Information Form," as adopted in Rule 69O-143.056, F.A.C.;

(c) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) - Primary Application";

(d) Form OIR-C1-1416, "Uniform Certificate of Authority (UCAA) Lines of Insurance", as adopted in Rule 69O-143.056, F.A.C.;

(e) Form OIR-C1-1422, "Uniform Certificate of Authority Application Questionnaire", as adopted in Rule 69O-136.034, F.A.C.;

(f) Form OIR-DO-896, "UCAA Proforma Financial Statements, Life & Health Insurer", as adopted in Rule 69O-143.056, F.A.C.;

(g) Form OIR-C1-1423, "Biographical Affidavit", as adopted in Rule 69O-143.056, F.A.C.;

(h) An investigative report in accordance with the instructions on Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," as adopted in Rule 69O-143.056, F.A.C.;

(i) Form OIR-C1-1524, "Uniform Consent to Service of Process", as adopted in Rule 69O-143.056, F.A.C.;

(j) Form OIR-C1-1389, "NAIC Company Code Application Form," rev. 2/16; and

(k) Form OIR-C1-XXXX, "Primary Application, Florida Specific Information", which includes Form OIR-C1-938, "Fingerprint Card Instructions", as adopted in Rule 69O-143.056, F.A.C.

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.34, 624.401, 624.404, 624.407, 624.411, 624.413, 624.414(1), 624.422, 624.466, 624.501, 625.306, 628.041, 628.6011, 628.051, 628.061, 628.071, 628.081, 628.091, 628.121, 628.151, 628.161, 628.171, 628.221, 628.231, 628.251, 628.261, 628.451, 628.461, 628.4615, 628.471, 629.071, 629.081, 629.091, 629.101, 629.121, 629.131, 629.181 FS. History–New 2-26-92, Amended 9-19-

00, 11-18-02, Formerly 4-136.011,Amended _____.

69O-136.012 Forms Adopted.

(1) All the forms listed in Rules 69O-136.002 through 69O-~~136.011~~ 136.034, F.A.C., are hereby adopted and incorporated by reference. Forms are available at http://www.floir.com/iportal. ~~All the forms may be obtained from and shall be submitted to the Office of Insurance Regulation, Division of Insurer Services, Applications Coordination Section, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0327.~~

(2) All filings pursuant to Chapter 69O-136, F.A.C. shall be submitted electronically to http://www.floir.com/iportal. ~~An original and one copy shall be filed for all applications referenced in Rules 69O-136.002 through 69O-136.011, F.A.C.~~

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.34, 624.401, 624.404, 624.413, 624.422, 624.462, 624.466, 624.501, 626.913, 628.6011, 628.051, 628.061 FS. History–New 2-26-92 Amended 9-19-00, Formerly 4-136.012,Amended _____.

69O-136.015 Procedure to Amend an Existing Certificate of Authority to Add a New Line of Business.

(1) The purpose of this rule is to establish a procedure for insurers to amend their certificates of authority by adding a new line of business. Since the addition of any new line of business to a company's certificate of authority may impact the company's surplus and/or writing ratios, any such request to amend an existing certificate will be carefully evaluated by applying current standards required of an insurer seeking a certificate of authority from this state.

(2) This rule applies to all authorized insurers, as defined in Section 624.09, F.S.

(3) Any insurer seeking to add a new line of insurance to an existing certificate of authority shall comply with the instructions for Corporate Amendments contained in the Uniform Certificate of Authority Application (UCAA) Instructions, in particular Sections I, II and XIII and any other requirements specifically listed or referenced including submitting the following forms and requirements therein ~~submit all of the following applicable forms~~:

(a) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) Instructions", rev. 12/16;

~~(a) Form OIR-C1-1339, "Application For Adding A New Line of Business," rev. 9/99;~~

(b) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) – Corporate Amendments Application Checklist";

~~(b) Form OIR-C1-1340, "Application For Adding A New Line of Business," rev. 9-96;~~

(c) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) - Corporate Amendments Application";

~~c Form OIR-C1-1341, "Invoice, Request for Certificate of Compliance for Amended Certificate of Authority," rev. 9/96;~~

(d) Form OIR-C1-1416, "Uniform Certificate of Authority (UCAA) Lines of Insurance", as adopted in Rule 69O-143.056, F.A.C.;

~~(d) Form OIR-C1-877, "Property and Casualty Insurers Lines of Business by Company Code," rev. 11/05/99;~~

(e) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) – Certificate of Compliance";

~~(e) Form OIR-C1-901, "Life, Accident and Health Insurers Classifications and Code Numbers," rev. 5/91;~~

(f) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) – Certificate of Deposit";

~~(f) Form OIR-C1-843, "Florida Comprehensive Health Association (FCHA) Subscription Agreement," rev. 5/91;~~

(g) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application Questionnaire for Adding Lines of Business";

~~g) Form OIR-C1-1093, "State of Florida Form for Small Employer Carrier's Application to Become a Risk Assuming Carrier or a Reinsuring Carrier," rev. 05/02.~~

(h) Form OIR-DO-896, "UCAA Proforma Financial Statements, Property and Casualty Insurance Company", as adopted in Rule 69O-143.056, F.A.C.;

(i) Form OIR-DO-896, "UCAA Proforma Financial Statements, Life & Health Insurer", as adopted in Rule 69O-143.056, F.A.C.; and

(j) Form OIR-DO-896, "UCAA Proforma Financial Statements, Health", as adopted in Rule 69O-143.056,

(4) The Office shall not authorize the addition of any lines of insurance to an insurer's existing certificate of authority unless evidence is presented satisfactory to the Office that authorization of the additional lines of insurance would be in the best interests of the financial solvency of the insurer and in the best interests of the policyholders.

~~(5) The forms in subsection (3) above are hereby adopted and incorporated by reference. All forms may be obtained from and shall be submitted to the Applications Coordination Section, Division of Insurer Services, Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, FL 32399-0326.~~

Rulemaking Authority 624.308(1) FS. Law Implemented 624.09, 624.307(1), 624.404, 624.408, 624.413, 624.414, 624.416(4), 624.501(20), 624.610(11), 627.6488(1) FS. History–New 3-30-92, Amended 9-2-96, Amended 9-19-00, 11-18-02, Formerly 4-136.01, Ammended_____.

69O-136.018 Determination of Eligibility to Operate as an Alien Insurer in Florida Pursuant to Sections ~~Section~~ 624.402(8) and (9), F.S.

All insurers domiciled outside the United States and registering pursuant to Section 624.402(8), F.S. or seeking eligibility pursuant to Section 624.402(9), F.S. shall submit the following applicable form and requirements therein:

~~(1) The form adopted in subsection (2) below, is to be used in determination of eligibility to operate as an Alien Insurer Pursuant to Section 624.402(8), F.S. All forms may be obtained from the Office's website: www.floir.com. All forms may be reproduced at will.~~

(1) ~~(2)~~ Form OIR-C1 ~~A2~~ -1654, rev. 4/16 ~~(REV 02/2006)~~, "Determination of Eligibility to Operate as an Alien Insurer in Florida Pursuant to Section 624.402(9)~~(8)~~, F.S." ~~is hereby incorporated by reference and is to be used in determination of eligibility to operate as an alien insurer pursuant to Section 624.402(8), F.S.~~ ; or

(2) Form OIR-C1-2176, "Letter of Notification/ Registration to Operate As a Non-U.S Based (Alien) Insurer (also Referred to as "Offshore Insurer") in Florida Pursuant to Section 624.402(8), F.S." .

Rulemaking Authority 624.308 FS. Law Implemented 624.402(8) FS. History–New 5-25-06 Amended_____.

69O-136.031 Registration as a Purchasing Group.

(1) All entities seeking registration as a purchasing group shall comply with the requirements of Section 627.948, F.S., and shall submit:

(a) Form OIR-C1-515, "Application for Registration as a Purchasing Group ~~— Notice and Registration~~," rev. 5/17 ~~10/07/99~~;

(b) Form OIR-C1-144, "Service of Process Consent & Agreement," rev. 6/04 ~~1/97~~;

(c) All purchasing groups shall comply with the information contained in Form OIR-C1-515, "Purchasing Group – Notice and Registration," rev. 12/05 ~~10/07/99~~ and submit the following forms where applicable:

~~1. Form OIR-C1-903, "Invoice, Request for Payment of Fingerprint Charges," rev. 4/97;~~

1.~~2.~~ Form OIR-C1-1423, "Biographical Affidavit", as adopted in Rule 69O-143.056, F.A.C. ~~Form OIR-C1-422, "Biographical Statement and Affidavit," rev. 10/26/98~~;

~~3. Form OIR-C1-450, "Authority for Release of Information," rev. 5/00;~~

2.~~4.~~ Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports", as adopted in Rule 69O-143.056, F.A.C. ~~rev. 2/01~~; and,

3.~~5.~~ Form OIR-C1-938, "Fingerprint Card Instructions", as adopted in Rule 69O-143.056, F.A.C. ~~rev. 7/99~~.

(2) In addition to the information required on the forms in subsection (1) above, the entity shall:

(a) Identify all other states in which the group is currently registered;

(b) Specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this sta© and,

(c) Provide such other information as is necessary for the Office to determine whether the persons through whom insurance will be offered meet the standard set forth in Section 626.611(14), F.S.

(3) During the pendency of the application, if any of the information submitted in response to the requirements of this rule changes, the entity shall notify the Office ~~Department~~ of the change within ten days of the change.

~~(4) The forms in subsection (1) above are hereby adopted and incorporated by reference. All forms may be obtained from and shall be submitted to the Applications Coordination Section, Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, FL 32399-0326.~~

Rulemaking Authority 624.308, 627.954 FS. Law Implemented 624.307(1), (3), 624.318, 624.321, 626.611(14), 627.948 FS. History–New 1-30-91, Formerly 4-107.002, Amended 9-19-94, Amended 9-19-00, 11-18-02, Formerly 4-136.031, Amended _____.

69O-136.032 Registration as a Risk Retention Group.

(1) All entities seeking licensure as a risk retention group shall comply with the requirements of Sections 627.943 or 627.944, F.S., as applicable, and shall submit all of the following:

(a) Form OIR-C1-513, "Application for Registration as a Risk Retention Group with Addendum," rev. 5/17 ~~rev. 11-90~~;

(b) Form OIR-C1-144A, "Appointment of Attorney To Accept Service," rev. 11/90 ~~11-90~~; and,

(c) Form OIR-C1-514, "Resolution Form," rev. 11/90 ~~11-90~~.

(2) In addition to the information required on the forms in subsection (1) above, the entity shall utilize Form OIR-A1-1615, "Transmittal of Premium Taxes for Risk Retention Groups (RRG's)" and remit its quarterly premium tax in accordance with the instructions contained therein.

Rulemaking Authority 624.308, 627.954 FS. Law Implemented 624.307(1), (3), 624.318, 624.321, 624.404(3)(a), 624.413, 627.943, 627.944, 628.051, 628.061 FS. History–New 1-30-91, Formerly 4-107.003, 4-136.032 Amended _____.

69O-136.034 Uniform Certificate of Authority Expansion Application (Foreign and Alien Insurers Filing for Certificate of Authority).

(1) All ~~Effective December 1, 2000, any~~ foreign and alien insurers seeking a certificate of authority pursuant to Sections 624.404 and 624.413, and related F.S., ~~may file a Uniform Certificate of Authority Expansion Application which is substantially similar to that form as revised by the National Association of Insurance Commissioners as of August 1, 2000 in lieu of the filings required by Rule 69O-136.002, F.A.C. Each applicant~~ shall comply with the

instructions for an Expansion Application as contained in the Uniform Certificate of Authority ~~Expansion~~ Application (UCAA) Instructions and any other requirements specifically listed or referenced ~~in the Uniform Certificate of Authority Expansion Application package, Form OIR-C1-1413,~~ including submitting the following forms and requirements therein. Such filings shall not exempt a foreign or alien insurer from any requirements under F.S.

(a) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) Instructions, rev.12/16;

~~(2) The following forms are incorporated by reference:~~

~~(a) Form OIR-C1-1413, "Uniform Certificate of Authority Expansion Application", as revised by the National Association of Insurance Commissioners on 8/1/00;~~

~~(b) Form OIR-C1-938, "Fingerprint Card Instructions", rev. 7/99;~~

~~(3) Each applicant shall submit the following forms:~~

(b) ~~(a)~~ Form OIR-C1-1414, "Uniform Certificate of Authority Application (UCAA) - Expansion Application Checklist", rev. 3/15 ~~8/00~~;

(c) ~~(b)~~ Form OIR-C1-1415, "Uniform Certificate of Authority Application (UCAA) - Expansion Application", rev. 8/14 ~~as revised 8/1/00~~;

(d) ~~(c)~~ Form OIR-C1-1416, "Uniform Certificate of Authority (UCAA) Lines of Insurance", as adopted in Rule 69O-143.056, F.A.C. ~~Expansion Application Lines of Business, rev. 8/00~~;

~~(e) (d) Form OIR-C1-1417, Expansion Application Authorization for Disclosure of Financial Records, rev. 8/00;~~

~~(e) Form OIR-C1-1418, Expansion Application Power of Attorney to Appoint and Certify Agents, rev. 8/00;~~

~~(f)~~ Form OIR-C1-1419, ~~Expansion Application~~ "Uniform Certificate of Authority Application (UCAA) - Certificate of Compliance", rev. 8/14 ~~8/00~~;

(f) Form OIR-C1-XXXX, "Uniform Certificate of Authority Application (UCAA) – Certificate of Deposit, rev. 8/15;

(g)~~(g) Form OIR-C1-1420, Expansion Application Reinsurance Arrangements Checklist for Proportional Treaty Contract Clauses, rev. 8/00;~~

~~(h) Form OIR-C1-1421, Expansion Application Reinsurance Arrangements Checklist for Non-Proportional Treaty Contract Clauses, rev. 8/00;~~

~~(i)~~ Form OIR-C1-1422," Uniform Certificate of Authority Application Questionnaire", rev. 11/14 ~~8/00~~;

(h) Form OIR-C1-1524, "Uniform Consent to Service of Process", as adopted in Rule 69O-143.056, F.A.C.;

(i) ~~(j) Form OIR-C1-881, Invoice, Application for Certificate of Authority, rev. 10/97;~~

~~(k) Form OIR-C1-1301, Subscription Agreement Form, rev. 5/99;~~

~~(l) Form OIR-C1-144, Service of Process Consent & Agreement, rev. 1/97;~~

~~(m)~~ Form OIR-C1-1423, ~~NAIC~~ "Biographical ~~Statement and~~ Affidavit", as adopted in Rule 69O-143.056, F.A.C. ~~rev. 8/00~~;

(j) An investigative report in accordance with the instructions on Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," as adopted in Rule 69O-143.056, F.A.C.;

(k) Form OIR-C1-1298, "Uniform Certificate of Authority Application (UCAA) - Management Information Form," as adopted in Rule 69O-143.056, F.A.C.;

(l) Form OIR-DO-896, "UCAA Proforma Financial Statements, Property and Casualty Insurance Company", as adopted in Rule 69O-143.056, F.A.C.;

(m) Form OIR-DO-896, "UCAA Proforma Financial Statements, Life & Health Insurer", as adopted in Rule 69O-143.056, F.A.C.;

(n) Form OIR-DO-896, "UCAA Proforma Financial Statements, Title Insurance Company", as adopted in Rule 69O-143.056, F.A.C.;

~~(n) Form OIR-C1-450, Authority For Release of Information, rev. 5/00;~~

(o) Form OIR-DO-896, "UCAA Proforma Financial Statements, Health", as adopted in Rule 69O-143.056, F.A.C.;

~~(o) Form OIR-C1-903, Invoice, Request for Payment of Fingerprint Charges, rev. 4/97;~~ and,

(p) Form OIR-C1-1424, "Expansion Application, Florida Specific Information", rev. 4/13 ~~8/00~~.

~~(4) The Office shall accept a Uniform Certificate of Authority Expansion Application filing in an electronic format after July 1, 2001.~~

Rulemaking Authority 624.308 FS. Law Implemented 624.307(1), 624.316(2)(b), 624.321(1)(a), 624.34, 624.401, 624.404, 624.407, 624.413, 624.422, 624.501, 626.9891, 628.161, 628.907 FS. History–New 12-3-00, Formerly 4-136.034, Amended _____.

Applicant Company Name: _____

NAIC No. _____
FEIN: _____

Uniform Certificate of Authority Application (UCAA)
Corporate Amendments Application
Application to Amend Certificate of Authority

To the Insurance Commissioner/Director/Superintendent of the State of:

(Check the appropriate states in which the Applicant Company is applying.)

Alabama		Montana	
Alaska		Nebraska	
Arizona		Nevada	
Arkansas		New Hampshire	
California		New Jersey	
Colorado		New Mexico	
District of Columbia		New York	
Connecticut		North Carolina	
Delaware		North Dakota	
Florida		Ohio	
Georgia		Oklahoma	
Hawaii		Oregon	
Idaho		Pennsylvania	
Illinois		Puerto Rico	
Indiana		Rhode Island	
Iowa		South Carolina	
Kansas		South Dakota	
Kentucky		Tennessee	
Louisiana		Texas	
Maine		Utah	
Maryland		Vermont	
Massachusetts		Virginia	
Michigan		Washington	
Minnesota		West Virginia	
Mississippi		Wisconsin	
Missouri		Wyoming	

(Check the appropriate states in which the Applicant Company is applying.)

The Uniform Certificate of Authority Corporate Amendments Application can be used to file more than one change in the same submission. The Applicant Company should mark all changes being filed on the application form and submit all items required for those changes in one package.

(Check the type of transaction for which the Applicant Company is applying.)

☐ Add Lines of Business: The undersigned Applicant Company hereby certifies that the lines of insurance as indicated on the Lines of Insurance Form 3 are all lines of business that (a) the Applicant Company is currently authorized to transact, (b) are currently transacted, and (c) which the Applicant Company is applying to transact.

☐ Name Change

☐ Delete Lines of Business

☐ Redomestication of a Foreign Insurer

☐ Change of Statutory Home Office Address

☐ Merger of Two or More Foreign Insurers

_____ Name of Non-Surviving Insurer and Cocode

☐ Pre-notification of Change of Control of Foreign Insurer

☐ Notification of Change of Control of Foreign Insurer

☐ Amended Articles of Incorporation

☐ Amended Bylaws

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Applicant Company Name: _____ NAIC No. _____

Effective Date of Name Change: _____ FEIN: _____

Previous Name of Applicant Company:

_____

New Name of Applicant Company:

_____

Did the Applicant Company experience a merger or an owner change prior to the name change?

Yes ☐ No ☐

If yes, please be sure an application is also submitted for the merger and/or ownership change transaction.

Effective Date of Change of Control of Foreign Insurer: _____

Previous Group Name: _____ Group Code: _____

New Group Name: _____ Group Code: _____

Has the Applicant Company's designee to appoint and remove agents changed as a result of this corporate amendment?

Yes ☐ No ☐

If yes, please note the new designee (name natural persons only): _____

Effective Date of Redomestication: _____ Previous State: _____ New State: _____

Effective Date of Statutory Home Office Address Change: _____

Previous Statutory Home Office Address: _____

E-Mail Address: _____ Phone: _____ Fax: _____

New Statutory Home Office Address: _____

E-Mail Address: _____ Phone: _____ Fax: _____

Previous Administrative Office Address: _____

E-Mail Address: _____ Phone: _____ Fax: _____

New Administrative Office Address: _____

E-Mail Address: _____ Phone: _____ Fax: _____

Previous Mailing Address: _____

E-Mail Address: _____ Phone: _____ Fax: _____

New Mailing Address: _____

E-Mail Address: _____ Phone: _____ Fax: _____

If a merger of two or more foreign insurers:

Effective Date of Merger: _____

Current Name of Surviving Applicant Company:

_____ NAIC No.: _____ Group Code: _____

Proposed New Name of Surviving Applicant Company:

_____ NAIC No.: _____ Group Code: _____

Name of Non-Surviving Insurer:

_____ NAIC No.: _____ Group Code: _____

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

Name of Surviving Insurer: _____ NAIC No.: _____ Group Code: _____

Surviving Applicant Company's Home Office Address: _____

Surviving Applicant Company's Administrative Office Address: _____

Surviving Applicant Company's Mailing Address: _____

Surviving Applicant Company's Telephone: _____ Fax: _____

Are these addresses the same as those shown on the Applicant Company's Annual Statement?

Yes ☐ No ☐

If not, indicate why: _____

Date of Last Market Conduct Examination: _____

Has the Applicant Company had an application for these lines of business refused by this or any other state prior to the date of this application?

Yes ☐ No ☐

If yes, give full explanation in an attached letter.

The following information is required of the individual (Applicant Company employee or paid consultant) who is authorized to represent the Applicant Company before the department.

Name: _____
Title: _____
Mailing Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

If the representative is not employed by the Applicant Company, please provide a company contact person in order to facilitate requests for detailed financial information.

Name _____
Title _____
Mailing Address _____
E-Mail Address: _____ Phone: _____ Fax: _____

Please provide a listing of all other applications filed by the Applicant Company, or any of its affiliates, which are pending before the Department:

_____

_____

A Certificate of Compliance from the Applicant Company's state of domicile (for foreign applicants) and the Applicant Company's original Certificate of Authority or an Affidavit of Lost Certificate of Authority must accompany this application. (not applicable for Change of Control, Amended Articles of Incorporation or Amended Bylaws.)

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Applicant Company Name: _____

NAIC No. _____
FEIN: _____

Applicant Company Officers' Certification and Attestation

One of the three officers (listed below) of the Applicant Company must read the following very carefully before signing:

1. I hereby certify, under penalty of perjury, that I have read the application, that I am familiar with its contents, and that all of the information, including the attachments, submitted in this application is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license discipline or other administrative action and may subject me, the Applicant Company, or both, to civil or criminal penalties.

2. I acknowledge that I am familiar with the insurance laws and regulations of the jurisdictions in which the Applicant Company is licensed or to which the Applicant Company is applying for licensure.

3. I acknowledge that I am the _____ of the Applicant Company, am authorized to execute and am executing this document on behalf of the Applicant Company.

4. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct, executed at _____.

_____ Date

_____ Signature of President

_____ Full Legal Name of President

_____ Date

_____ Signature of Secretary

_____ Full Legal Name of Secretary

_____ Date

_____ Signature of Treasurer

_____ Full Legal Name of Treasurer

_____ Applicant Company

_____ Date

_____ Signature of Witness

_____ Full Legal Name of Witness

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

Uniform Certificate of Authority Application
QUESTIONNAIRE
For Adding or Deleting Lines of Business to an Existing Certificate of Authority

Directions: Complete **Section I** (questions 1 – 21) for adding new lines of business. Complete **Section II** (questions 22 through 25) for deleting lines of business. Each "Yes" or "No" question is to be answered by marking an "X" in the appropriate space. All questions should be answered. If the Applicant Company denotes a question as "Not Applicable" (N/A) an explanation must be provided. Other answers and additional explanations or details may be provided in writing attached to the affidavit. Please complete this form and file it with the Applicant Company's application to change lines of business to its Certificate of Authority.

Section I

1. Has the Applicant Company merged or consolidated with any other company within the last five years?

   Yes ____ No ____

2. Have any of the following taken place since the date of the Applicant Company's most recent Annual Statement?

   A. Is the Applicant Company presently negotiating for or inviting negotiations for any transaction as described in question 1 above?

      Yes ____ No ____

   B. A change of management or control?

      Yes ____ No ____

   C. Does the Applicant Company contemplate a change in management or any transaction which would normally result in a change of management within the next 12 months?

      Yes ____ No ____

   If the answer to any question is yes, provide the details in writing and attach to the Questionnaire.

3. A. Has the Applicant Company's certificate of authority to do business in any state been suspended or revoked within the last five years?

      Yes ____ No ____

   B. Has the Applicant Company's application for admission to any state been denied within the last five years?

      Yes ____ No ____

   C. Has the Applicant Company's application to add lines of business to its Certificate of Authority in any state been denied within the last five years?

      Yes ____ No ____

   If the answer to any of the above question is yes, provide the details in writing and attach to the Questionnaire.

4. Since the date of the most recent Annual Statement, has any person who is presently an officer, director, or shareholder of the Applicant Company, been convicted of, or pleaded guilty, or nolo contendere to, a felony charge for theft, larceny or mail fraud, or of violating any corporate securities statute or any insurance statute?

   Yes ____ No ____

   If yes, provide the details in writing and attach to the Questionnaire.

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Applicant Name: _____ NAIC No. _____
FEIN: _____

5. Is the Applicant Company presently engaged in a dispute with any state or federal regulatory agency?

Yes ____ No ____

If yes, provide the details in writing and attach to the Questionnaire.

6. Is the Applicant Company a plaintiff or defendant in any legal action other than one arising out of policy claims?

Yes ____ No ____

If yes, provide a summary of each case and attach to the Questionnaire.

7. Has the Applicant Company, within 18 months last preceding the date of this affidavit, entered into any material transactions, as defined in the NAIC Model Law on Material Transactions, with any affiliate, officer, director, trustee, or shareholder which has not been approved in writing by the state of domicile? Material transactions include: loans, transfers of assets, purchases of assets, reductions of liabilities, or reinsurance transactions.

Yes ____ No ____

If yes, provide the details in writing and attach to the Questionnaire.

8. Please explain the Applicant Company's experience, expertise or background regarding the requested lines of business. This explanation should be specific and include documentation which shows the amount of time the Applicant Company has written this product, premium volumes, profitability of the Applicant Company, applicable managerial experience and other information which demonstrates that the Applicant Company has experience in writing the requested line of business sufficient to satisfy the seasoning or experience requirements of the state in which the application is being submitted.

9. Provide a list of any affiliated parties that will be involved in the marketing, underwriting, servicing, administration, premium financing, claims adjustment or claims payment for the requested lines of business.

10. Provide a detailed description of the Applicant Company's sales techniques for the requested lines of business. The description should include:

A. Information regarding recruitment and training of sales representatives.

B. Identification as to whether the Applicant Company will be a direct writer or will use agents, brokers, or a combination thereof.

C. Explanation of the compensation and control to be provided by the Applicant Company to its agents, brokers or sales personnel.

D. Identification of any specific agency, third party administrator, or managing general agent, and a copy of the agreement.

11. For each state in which the Applicant Company is filing, provide the following for the requested lines of business:

A. The product lines to be sold by the Applicant Company,

B. The Applicant Company's marketing plan, including a description of the financial, corporate, or other connections productive of insurance,

C. The Applicant Company's current and expected competition (both regionally and nationally) and

D. Include a detailed explanation as to how the Applicant Company will develop, purchase, control and supervise its advertising.

A general description of the classes to be transacted is not an adequate response. For example, if the Applicant Company plans to market credit life and disability products tailored for use by credit unions, simply stating that it will transact credit life and disability is inadequate.

12. If a parent, subsidiary, and/or affiliated insurer is already admitted for the classes of insurance requested in the pending application, differentiate the products and/or markets of the Applicant Company from those of the admitted insurer(s).

13. Explain in detail how (a) the Applicant Company's policies will be underwritten, including the issuance of policies and endorsements (b) policies will be cancelled and (c) premiums and other funds will be handled, including:

    A. Identify the entity that will perform each of these functions.

    B. If personnel performing these functions will be shared with another entity, or if another entity will be performing these functions, provide an explanation of this arrangement.

14. Explain in detail how the Applicant Company will adjust and pay claims.

    A. Identify the entity that will perform the Applicant Company's claims adjusting and claims payment functions.

    B. If personnel for claims adjusting or claims payment will be shared with another entity, or another entity will be performing the Applicant Company's claims adjusting and claims payment, please explain this arrangement, including any affiliation with the Applicant Company.

    C. Provide detailed information as to how and by whom claim reserves will be set and modified.

    D. Does the Applicant Company pay any representative given discretion as to the settlement or adjustment of claims under life or disability policies, whether in direct negotiation with the claimant or in supervision of the person negotiating, a compensation which is in any way contingent upon the amount of settlement of such claims?

    Yes ____ No ____

    If yes, please provide a detailed explanation and attach to Questionnaire.

15. Is the Applicant Company a member of a group of companies that shares any of the following:

    A. Common facilities with another company or companies

    Yes ____ No ____

    B. Services (e.g. accounting personnel for financial statement preparation)

    Yes ____ No ____

    If the answer to any of the above is yes please provide a detailed explanation and attach to Questionnaire.

16. Provide a company-wide, three-year pro forma balance sheet and income statement. For the lines being requested, provide (3) year premium and loss projections by line for the state in which additional lines of business have been requested. Projections should support all aspects of the proposed plan of operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections.

17. Provide an explanation of any reinsurance that will be entered into, or that is currently in place covering the requested lines of business. Provide details and attach to the Questionnaire.

18. Are any of the Applicant Company's policies being sold in connection with mutual funds or investments in securities?

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Yes ____ No ____ Not Applicable ____

If yes, supply details including all sales literature which refers to the insurance and mutual fund or other investment plan connection.

19. If the Applicant Company is applying for authority to write Variable Annuities, provide the following:

A. Copy of any third party management or service contracts

B. Commission schedules

C. Five-year sales and expense projections

D. A statement from the Applicant Company's actuary describing reserving procedures including the mortality and expense risks which the Applicant Company will bear under the contract

E. Statement of the investment policy of the separate account

F. Copy of the variable annuity prospectus properly filed with the SEC

G. Copies of the variable annuity laws and regulations of the state of domicile

H. Copy of the variable annuity contract and application

I. A description of any investment advisory services contemplated relating to Separate Accounts

J. Board of Directors resolution authorizing the creation of the separate account.

20. If the Applicant Company is applying for authority to write Variable Life Insurance, provide the following:

A. Copy(ies) of variable life policy(ies) the Applicant Company intends to issue

B. Name and experience of person(s) or firm(s) proposed to supply consulting, investments, administrative, custodial or distribution services to the Applicant Company

C. Disclose whether each investment advisor, 1) is registered under the Investment Advisers Act of 1940, or 2) is an investment manager under the Employee Retirement Income Security Act of 1974, or 3) whether the Applicant Company will annually file required information and statements concerning each investment advisor as required by its domiciliary state.

D. Copy of the variable life prospectus properly filed with the SEC

E. Statement of the investment policy of any separate account, and the procedures for changing such policy

F. Copies of the variable life insurance laws and regulations of the state of domicile

G. A statement from the Applicant Company's actuary describing reserving procedures including the mortality and expense risks which the Applicant Company will bear under the contract.

H. Standards of suitability or conduct regarding sales to policyholders

I. Statement authorizing the creation of the separate account (i.e. Board resolution)

J. Statement specifying the standards of conduct with respect to the purchase or sale of investments of separate accounts (i.e. Board resolution)

21. If the Applicant Company is applying for authority to write Life Insurance, has the Applicant Company at any time within the last five years, irrespective of changes in management, taught or permitted its agents to sell insurance by using any of the following devices, or representations resembling any of the following:

A. "Centers of influence" and "advisory board"

Yes____ No____

B. Charter or founder's policy

Yes____ No____

C. Profit sharing plan

Yes____ No____

D. Only a limited number of a certain policies will be sold in any given geographical area

Yes____ No____

E. "Profits" will accrue or be derived from mortality savings, lapses and surrenders, investment earnings, savings in administration

Yes____ No____

F. Printed list of several large American or Canadian insurers showing the dollar amounts of "savings", "profits" or "earnings" they have made in such categories

Yes____ No____

If the answer to any of the above is yes, supply a complete set of all sales material including the sales manual, all Applicant Company instructional material, brochures, illustrations, diagrams, literature, "canned" sales talks, copies of the policies which are no longer in use, list of states where such methods were used and the date (by year) when they were used, the approximate amount of insurance originally written in each state on each policy form thusly sold, the amount currently in force, and the lapse ratio on each form year by year and cumulatively in gross to the present date.

Section II

22. Utilizing the information contained in Form 3, list all of the lines of business that the Applicant Company requests to be deleted from its Certificate of Authority.

23. Provide a detailed explanation for the Applicant Company's request to delete these lines of business.

24. For each state, indicate the number of policyholders by line of business that will be non-renewed or cancelled if the Applicant Company's request to delete lines of business is approved.

25. Provide documentation that the Applicant Company has complied with all requirements for removal of lines of business from its Certificate of Authority, and withdrawal from the specified state.

Applicant Company Name: _____ NAIC No. _____

FEIN: _____

Uniform Certificate of Authority Application (UCAA)
Primary Application

To the Insurance Commissioner/Director/Superintendent of the State of:

(Check the appropriate states in which the Applicant Company is applying.)

Alabama		Montana	
Alaska		Nebraska	
Arizona		Nevada	
Arkansas		New Hampshire	
California		New Jersey	
Colorado		New Mexico	
District of Columbia		New York	
Connecticut		North Carolina	
Delaware		North Dakota	
Florida		Ohio	
Georgia		Oklahoma	
Hawaii		Oregon	
Idaho		Pennsylvania	
Illinois		Puerto Rico	
Indiana		Rhode Island	
Iowa		South Carolina	
Kansas		South Dakota	
Kentucky		Tennessee	
Louisiana		Texas	
Maine		Utah	
Maryland		Vermont	
Massachusetts		Virginia	
Michigan		Washington	
Minnesota		West Virginia	
Mississippi		Wisconsin	
Missouri		Wyoming	

The undersigned Applicant Company hereby certifies that the classes of insurance as indicated on the Lines of Insurance, Form 3, are all lines of business (a) currently authorized for transaction, (b) currently transacted and (c) which the Applicant Company is applying to transact.

Name of Applicant Company: _____ NAIC No.: _____ -- _____ Group Code

Home Office Address: _____

Administrative Office Address: _____

Mailing Address: _____

Phone: _____ Fax: _____

Are these addresses the same as those shown on the Applicant Company's Annual Statement?

Yes ☐ No ☐

If not, indicate why:

_____

_____

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

Date Incorporated: _____ Form of Organization: _____

Billing Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

Premium Tax Statement Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

Producer Licensing Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

Rate/Form Filing Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

Consumer Affairs Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

State or Country of Domicile: _____ Date Organized: _____

Date of Last Amendment of Charter, Bylaws or Subscriber's Agreement: _____

Date of Last Financial Examination: _____

Date of Last Market Conduct Examination: _____

Par Value of Issued Stock: $ _____ Surplus as regards policyholders: $ _____

Certificate of Deposit (Home State): $ _____

Ultimate Owner/Holding Company: _____

Has the Applicant Company ever been refused admission to this or any other state prior to the date of this application?

Yes ☐ No ☐

If yes, give full explanation in an attached letter.

The Applicant Company hereby designates (name natural persons only) _____, to appoint persons and entities to act as and to be licensed as agents in the State of _____, and to terminate the said appointments.

NOTE: This does not apply to those states that do not require appointments

The following information is required of the individual who is authorized to represent the Applicant Company before the department.

Name: _____
Title: _____
Mailing Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

If the representative is not employed by the Applicant Company, please provide a company contact person in order to facilitate requests for detailed financial information.

Name: _____
Title: _____
Mailing Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

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Applicant Company Name: _____

NAIC No. _____
FEIN: _____

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

Please provide a listing of all other applications filed by the Applicant Company, or any of its affiliates, that are pending before the Department.

_____

_____

Applicant Company Officers' Certification and Attestation

One of the officers (listed below) of the Applicant Company must read the following very carefully:

1. I hereby certify, under penalty of perjury, that I have read the application, that I am familiar with its contents, and that all of the information, including the attachments, submitted in this application is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license discipline or other administrative action and may subject me or the Applicant Company, or both, to civil or criminal penalties.

2. I acknowledge that I am familiar with the insurance laws and regulations of said state, accept the Constitution of such state, in which the Applicant Company is licensed or to which the Applicant Company is applying for licensure.

3. I acknowledge that I am the _____ of the Applicant Company, am authorized to execute and am executing this document on behalf of the Applicant Company.

4. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct, executed this _____ at _____.

_____ _____
Date Signature of President

_____
Full Legal Name of President

_____ _____
Date Signature of Secretary

_____
Full Legal Name of Secretary

_____ _____
Date Signature of Treasurer

_____
Full Legal Name of Treasurer

_____
Name of Applicant Company

_____ _____
Date Signature of Witness

_____
Full Legal Name of Witness

Applicant Company Name: _____ NAIC No. _____

FEIN: _____

Uniform Certificate of Authority Application (UCAA)
Primary Application Checklist
For Primary Application Only

The application checklist is intended to help guide the insurer (herein after referred to as "Applicant Company") with the assembly of a complete Primary Uniform Certificate of Authority Application (UCAA). Please be sure to complete the checklist by appropriately marking the boxes on the left side of the page prior to submitting the application for review. The completed checklist should be attached to the top of the application.

Regulator Use Only

1. **Application Form, containing:** ☐
   - ☐ Completed UCAA Primary Application Checklist (Form 1P)
   - ☐ Original UCAA Primary Application executed and signed (Form 2P)
   - ☐ Include all lines of insurance the Applicant Company is licensed to transact, currently transacting, and requesting authority to transact in all jurisdictions (Form 3).

2. **Filing Fee (pursuant to Section II Filing Requirements Item 2), containing:** ☐
   - ☐ Payment of required filing fee
   - ☐ Copy of check

3. **Minimum Capital and Surplus Requirements (pursuant to Section II Filing Requirements Item 3)** ☐
   - ☐ Provide explanation of compliance with minimum capital & surplus requirements for state for which application is prepared

4. **Statutory Deposit Requirements (pursuant to Section II Filing Requirements Item 4)** ☐
   - ☐ An original Certificate of Deposit prepared by state of domicile (Form 7)

5. **Name Approval (pursuant to Section II Filing Requirements Item 5)** ☐
   - ☐ Evidence of name approval request

6. **Plan of Operation (pursuant to Section II Filing Requirements Item 6)** ☐
   - ☐ Completed questionnaire (Form 8)
   - ☐ Pro Forma
   - ☐ Narrative

7. **Holding Company Act Filings (pursuant to Section II Filing Requirements Item 7)** ☐
   - ☐ Include Holding Company Act Filings, including Form B, Form F or substantially similar statement

8. **Statutory Membership(s)** ☐
   - ☐ Submit documentation as listed in Section II Filing Requirements Item 8

9. **SEC Filings or Consolidated GAAP Financial Statement** ☐
   - ☐ Submit documentation as listed in Section II Filing Requirements Item 9

10. **Debt-to-Equity Ratio Statement** ☐
    - ☐ Submit documentation as listed in Section II Filing Requirements Item 10

11. **Custody Agreements** ☐
    - ☐ Submit documentation as listed in Section II Filing Requirements Item 11

Applicant Company Name: _____ NAIC No. _____

FEIN: _____

Regulator Use Only

12. **Public Records Package – Submit ALL items in chart in Section II Item 12, including:** ☐

a. **Articles of Incorporation, including:** ☐
- ☐ Original certification by domiciliary state

b. **Bylaws, including:** ☐
- ☐ Original certification by the Applicant Company's corporate assistant

c. **Statement with attachments, including:** ☐
- ☐ Current year annual statement*, verified and signed, including actuarial opinion
- ☐ Current year quarterly statements (one copy for each quarter), verified and signed

*1. Updated statements should be submitted on a timely basis while application is pending.

2. If annual statement for two preceding years has not been filed with the NAIC, one copy of each year must be submitted with the application.

d. **Independent CPA Audit Report** ☐

13. **NAIC Biographical Affidavit (Form 11) for the following:** ☐
- ☐ Officers (as listed on Jurat Page of most recent financial statement)
- ☐ Directors (as listed on Jurat Page of most recent financial statement)
- ☐ Key managerial personnel (including any vice presidents or other individuals who will control the operations of the Applicant Company)
- ☐ Individuals with a 10% or more beneficial ownership in the Applicant Company who will exercise control over the Applicant Company or, officers and directors of an entity with a 10% or more beneficial ownership in the Applicant Company who exercise control over the Applicant Company; and
- ☐ Individuals with a 10% or more beneficial ownership in the Applicant Company's ultimate controlling person who will exercise control over the Applicant Company, and officers and directors of the ultimate controlling person who will control the operations of the Applicant Company
- ☐ Affidavit originally signed and notarized within one year of application date
- ☐ Affidavit certified by independent third party

14. **State-Specific Information** ☐
- ☐ Some jurisdictions may have additional requirements that must be met before a Certificate of Authority can be issued. Before completing a UCAA Primary Application, the Applicant Company should review a listing of requirements for the state to which it is applying.

Filing Requirements – Redomestications Only

The requirements of this section are only for those Applicant Company's seeking to redomesticate from one state to another and are in addition to the requirements of Section II, items 1-14 of the Primary Checklist. A Redomestication is defined as the process where any insurer organized under the laws of any other state may become a domestic insurer that transfers its domicile to another state by merger or consolidation or any other lawful method. The Primary Application when used for a redomestication is filed with the Applicant Company's new state of domicile.

15. **Annual Statement with Attachments** ☐
- ☐ Submit documentation as listed in Section III Filing Requirements Item 1

16. **Quarterly Statements** ☐
- ☐ Submit documentation as listed in Section III Filing Requirements Item 2

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17. **Risk-Based Capital Report** ☐

☐ Submit documentation as listed in Section III Filing Requirements Item 3

Applicant Company Name: _____ NAIC No. _____

FEIN: _____

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18. **Independent CPA Audit Report** ☐

☐ Submit documentation as listed in Section III Filing Requirements Item 4

19. **Reports of Examination** ☐

☐ Includes a copy of the most recent Report of Financial Examination from its domiciliary state and a note of all more recent examinations, completed by any state, including market conduct examinations along with a description of each examination.

20. **Certificate of Compliance (pursuant to Section III Filing Requirements Item 6** ☐

☐ Original certification of compliance (Form 6) completed by domiciliary state insurance regulatory agency

Applicant Company Name: _____ NAIC No. _____

FEIN: _____

Uniform Certificate of Authority Application (UCAA)
Corporate Amendments Application Checklist
For Corporate Amendments Application Only

The application checklist is intended to help guide the insurer (herein after referred to as "Applicant Company") with the assembly of a complete Corporate Amendments Uniform Certificate of Authority Application (UCAA). Please be sure to complete the checklist by appropriately marking the boxes on the left side of the page prior to submitting the application for review. The completed checklist should be attached to the top of the application.

Regulator Use Only

1. **Application Form (pursuant to Sections II-V and VII–X Filing Requirements Item 1), containing:**
   - ☐ Completed UCAA Corporate Amendments Application Checklist (Form 1C)
   - ☐ Original UCAA Corporate Amendments Application Form executed, signed and Attachments (Form 2C)
   - ☐ Original Certificate of Authority or an Affidavit of Lost Certificate of Authority (Form 15) (not applicable for Sections VIII, IX and X)
   - ☐ Cover Letter (Optional)

2. **Filing Fee (pursuant to Sections II-V and VII–X Filing Requirements Item 2), containing:**
   - ☐ Payment of required filing fee
   - ☐ Copy of check

3. **Articles of Incorporation/Articles of Merger (pursuant to Sections II-V, VII and IX Filing Requirements Item 3)**
   - ☐ Submit documentation as listed in Sections II-V, VII and IX Filing Requirements Item 3

4. **Bylaws (pursuant to Sections II-V, VII, IX Filing Requirements Item 4; Section X Filing Requirements Item 3)**
   - ☐ Submit documentation as listed in Sections II-V, VII and IX Filing Requirements Item 4 and Section X Filing Requirements Item 3

5. **Lines of Insurance (pursuant to Section II Filing Requirements Item 1)**
   - ☐ Include all lines of insurance the Applicant Company is licensed to transact, currently transacting and requesting authority to transact in all jurisdictions (Form 3)

6. **Minimum Capital and Surplus Requirements (pursuant to Sections II and VII Filing Requirements Item 5)**
   - ☐ Provide explanation of compliance with minimum capital & surplus requirements for state for which application is prepared

7. **Certificate of Deposit for Statutory Deposit Requirements (pursuant to Sections II and VII Filing Requirements Item 6; Section IV Filing Requirements Item 5)**
   - ☐ An original Certificate of Deposit prepared by state of domicile (Form 7)

8. **Plan of Operation (pursuant to Sections II, VII and VIII Filing Requirements Item 7)**
   - ☐ Completed Questionnaire (Form 8C) per Section II, Filing Requirements Item 7
   - ☐ Pro Forma (Form 13)
   - ☐ Narrative

9. **Deleting Lines of Business (pursuant to Section II Filing Requirements Item 11)**
   - ☐ Questionnaire (Form 8C), complete Section II, questions 22-25

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

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10. **Statutory Membership(s) (pursuant to Sections II and VII Filing Requirements Item 8)** ☐
    ☐ Submit documentation as listed in Sections II, and VII Filing Requirements Item 8

11. **Certificate of Compliance (pursuant to Section II Filing Requirements Item 9)** ☐
    ☐ Original Certificate of Compliance completed by domiciliary state insurance regulatory agency (Form 6)

12. **State-Specific Information (pursuant to Section II Filing Requirements Item 10, Sections III, V Filing Requirements Item 7, Section IV Filing Requirements Item 8, Section VII Filing Requirements Item 12, Section VIII Filing Requirements Item 9, Section IX Filing Requirements Item 6, Section X Filing Requirements Item 5 and Section XI Item 4)** ☐
    ☐ Some jurisdictions may have additional requirements that must be met before approval can be granted or the amended Certificate of Authority can be issued. Before completing a UCAA Corporate Amendments Application the Applicant Company should review a listing of requirements for the state to which they are applying. That listing can be found at **http://www.naic.org/industry_ucaa.htm**

13. **Uniform Consent to Service of Process (pursuant to Sections III, IV and V Filing Requirements Item 5, Section VII Filing Requirements Item 10 and Section VIII Filing Requirements Item 7)** ☐
    ☐ Original executed Service of Process form (Form 12)

14. **State of Domicile Approval (pursuant to Sections III, IV and V Filing Requirements Item 6 and Section VII Filing Requirements Item 11, Section VIII Filing Requirements Item 8, Section IX Filing Requirements Item 5 and Section X Filing Requirements Item 4)** ☐
    ☐ Submit documentation as listed in applicable Sections III, IV and V Item 6, Section VII Filing Requirements Item 11, Section VIII Fling Requirements Item 8, Section IX Filing Requirements Item 5 and Section X Filing Requirements Item 4

15. **NAIC Biographical Affidavit (Form 11), (pursuant to Section VII Filing Requirement Item 9 and Section VIII Filing Requirement Item 6), for the following:** ☐
    ☐ Officers (as listed on Jurat Page of most recent financial statement.)
    ☐ Directors (as listed on Jurat Page of most recent financial statement.)
    ☐ Key managerial personnel (including any vice presidents or other individuals who will control the operations of the applicant.)

16. **Name Approval (pursuant to Section III Filing Requirements Item 8)** ☐
    ☐ Evidence of name approval request

17. **Statement of Withdrawal (pursuant to Section XI Filing Requirements Item 3)** ☐
    ☐ Completed Form 17

    Submit documentation, if applicable, for:
    ☐ Reinsurance Agreement
    ☐ Assumption Agreement
    ☐ Outstanding Liabilities or Law suits
    ☐ Pending Regulatory Actions

APPLICATION FOR CERTIFICATE OF AUTHORITY DOMESTIC RECIPROCAL INSURER

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.

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

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

APPLICATION FOR CERTIFICATE OF AUTHORITY
DOMESTIC RECIPROCAL INSURER

INSTRUCTIONS
SECTION I - APPLICATION FORM & FEES

Section I-1 Application Fees

Applicants must pay an application fee of $1,500 and a company license tax of $1,000. These fees are due at the time the application package is filed, and the filing fee is NON-REFUNDABLE.

Secure your check to the INVOICE (included in this package) and send to:

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

Place a copy of the INVOICE and a copy of the check with your online application filing via iApply. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section I-2 Fingerprint Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-4. Please see Form OIR-C1-938 for instructions. The fingerprint cards are to be submitted at the time of the application filing.

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 to Conduct Business in the State of Florida

On this form, list the lines of business by code (see Form OIR-C1-1416) you intend to write in the State of Florida. The lines of business listed must be consistent, with the lines listed in the plan of operations submitted with this package. When a Certificate of Authority is issued by the Office of Insurance Regulation, it will include only those lines listed on this form and addressed in the pro formas in the plan of operations. It must be under corporate seal and signed (original signatures) by both the President or Chief Executive Officer and the Secretary of the company.

APPLICATION FOR CERTIFICATE OF AUTHORITY DOMESTIC RECIPROCAL INSURER

SECTION II - LEGAL

THE OFFICE OF INSURANCE REGULATION RECOMMENDS THAT CORPORATE DOCUMENTS BE REVIEWED BY YOUR LEGAL COUNSEL. THE DEPARTMENT IS A FILING AGENCY AND AS SUCH DOES NOT RENDER ANY LEGAL, ACCOUNTING OR TAX ADVICE. THE PROFESSIONAL ADVICE OF YOUR LEGAL COUNSEL TO ASCERTAIN EXACT COMPLIANCE WITH ALL STATUTORY REQUIREMENTS IS STRONGLY RECOMMENDED.

NOTE THAT PURSUANT TO SECTION 629.051 THE NAME OF THE INSURER MUST INCLUDE THE WORD "RECIPROCAL," OR "INTERINSURER," OR "INTERINSURANCE," OR "EXCHANGE," OR "UNDERWRITERS," OR "UNDERWRITING."

Section II-1 Consent and Agreement in re Service of Process (Official Form)

The Consent and Agreement in re Service of Process form (form attached) is to be accompanied by the Resolution of the Subscribers Advisory Committee authorizing execution thereof (Section II-2). **NO** other signature will be accepted other than that of the Chairman of the Subscribers Advisory Committee which must be under seal.

Section II-2 Resolution Form - (Consent and Agreement in re Service of Process Original Form)

This resolution (form attached) gives specific authority to the Chairman of the Subscribers Advisory Committee to execute the agreement. The enclosed Office of Insurance Regulation Resolution Form must be used. Individualized or amended forms are unacceptable. **NO** other signatures will be accepted other than those of the Chairman of the Subscribers Advisory Committee and Secretary which must be under seal.

Section II-3 Attorney-in-Fact

The following declaration must be submitted by the Attorney-in-Fact:

1. The name of the insurer;
2. The location of the insurer's principal office, which shall be the same as that of the attorney-in-fact and shall be located in this state;
3. The kinds of insurance proposed to be transacted;
4. The names and addresses of the original subscribers;
5. A copy of the designation and appointment of the proposed attorney-in-fact and a copy of the power of attorney;
6. The names and addresses of the officers and directors of the attorney-in- fact, if a corporation, or its members, if other than a corporation;

SECTION II - LEGAL

7. The powers of the subscribers' advisory committee, and the names and terms of the members thereof;
8. A statement that all moneys paid to the reciprocal shall, after deducting therefrom any sum payable to the attorney, be held in the name of the insurer and for the purposes specified in the subscribers agreement;
9. A copy of the subscribers agreement;
10. A statement that each of the original subscribers has in good faith applied for insurance of a kind proposed to be transacted, and that the insurer has received from each such subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than 6 months at an adequate rate theretofore filed with and approved by the department;
11. A statement of the financial condition of the insurer, a schedule of its assets, and a statement that the surplus as required by s. 629.071 is on hand;
12. A copy of each policy, endorsement, and application form it then proposes to issue or use.

Such declaration shall be acknowledged by the attorney-in-fact before an officer authorized to take acknowledgements.

Section II-4 Attorney-in-Fact Bond

Pursuant to section 629.121 a bond in the amount of $100,000, with an authorized corporate surety subject to the approval of the Office must be filed with this section of the application. A deposit may be maintained with the Office in lieu of bond as provided for in section 629.131.

Section II-5 Secretary of State Registration Requirements

The Attorney-in-Fact for the Reciprocal must register as a domestic or foreign corporation with the Florida Secretary of State, www.sunbiz.org.

Section II-6 Certificate of Status (Attorney-in-Fact)

Provide the Certificate of Status obtained from the Florida Secretary of State (www.sunbiz.org) with the application filing.

Section II-7 Articles of Incorporation (Attorney-in-Fact)

Provide certified Articles of Incorporation obtained from the Florida Secretary of State (www.sunbiz.org) with the application filing.

APPLICATION FOR CERTIFICATE OF AUTHORITY
DOMESTIC RECIPROCAL INSURER

SECTION III - FINANCIAL

Section III-1 Statutory Deposit

Pursuant to Section 624.411, every domestic insurer shall be required to file a statutory deposit with the Office for the protection of the insurer's policyholders and creditors. This deposit shall have at all times a value of not less than:

(a) $250,000 to transact casualty insurance
(b) $100,000 to transact all other kinds of insurance, per kind of insurance
(c) A maximum of $300,000 for any insurer authorized to write more than one kind of insurance.

Contact the Bureau of Collateral Management, Insurance Deposits Section, (850) 413-3164 for the procedures involved in establishing a deposit.

Include verification from the Bureau of Collateral Management that the funds have been deposited with the application.

Section III-2 Verification of Funds

To obtain a Certificate of Authority in Florida an insurer is required to have a minimum of $1 million in surplus as to policyholders. These funds should be held in a financial institution pursuant to Section 625.306, Florida Statutes.

The funds must be verified by a letter from an officer of the financial institution where the funds are being held and should include the following:

1. Name of depositor and Federal ID Number.
2. Account numbers and amounts of funds in each account.
3. Form of funds on deposit.
4. If funds are in the form of a certificate of deposit, include certificate numbers and maturity dates.
5. Any restrictions on the withdrawal of the funds.

Section III-3 Plan of Operation

It is important for the Office to have a clear understanding of the proposed operations of the new insurer and the goals it seeks to achieve. To meet this requirement the applicant

SECTION III - FINANCIAL

shall furnish a three-year Plan of Operations. If the applicant company is owned or controlled by a Financial Institution as defined in Section 626.9885, Florida Statutes, please refer to restrictions outlined in this statute when developing the Plan of Operations. The plan must include all major areas of the proposed operations including but not limited to the following:

(A) A brief history of the company since its incorporation.

(B) A brief description of the management experience of each individual (by name) involved in the following areas: Marketing, Underwriting, Rating, Reserving, Reinsurance, Claims Handling, Accounting, Investments, and Managing General Agents.

(C) Description of each line of insurance products to be marketed and planned dates of initial marketing of each line.

(D) A three year plan of marketing, including commission rates, use of brokering agents, third party administrators, and other administrative expenses.

(E) Provide planned use of reinsurance including the purpose of the reinsurance and the degree to which it is to be used in relation to the amount of insurance in force. Include retentions and limits of liability for the proposed reinsurance as well as catastrophe and coverage and the largest amount retained on one risk.

(F) Submit a statement regarding any planned changes in operations during the next three years. If no changes are planned, a statement to that effect.

(G) Provide a list of all assumptions used in projections and pro formas and disclose how these assumptions were derived. The assumptions should at least address how the premium levels have been derived, commission rates, investment income yields, expense levels, and benefits payable under accident and health policies and contracts.

(H) Furnish pro forma statutory balance sheet and statutory income and expense statements covering the accounts in the format on the attached forms (5 - 22). If you should have any questions concerning individual line items please refer to the NAIC instructions to the annual statement.

(I) Furnish a list of all consultant and expert services in use or proposed during the three-year period.

APPLICATION FOR CERTIFICATE OF AUTHORITY
DOMESTIC RECIPROCAL INSURER

SECTION III - FINANCIAL

(J) Provide planned premium volume for countrywide premium and Florida premium by line of insurance at three-month intervals for a three-year period from initial marketing date for each line of insurance.

Section III-4 Statement of Method Used in Financing Insurer

Provide a statement of method to be used in the financing of the proposed insurer. This statement shall include the following:

1. The amount of surplus as to policyholders to be funded.

   (a) By source (contributed by whom)
   (b) Amounts funded by each source
   (c) The form in which the funding will be made, i.e., state specific dollar amounts of specific stocks, bonds, certificates of deposit, cash, etc.

2. Residence addresses, business background and qualifications of all individuals named in 1 above.

3. Copies of all syndicate, association, firm, partnership, organization or other similar agreements involved in the formation or financing of proposed insurer.

4. Copies of any securities or of any proposed document evidencing any right or interest proposed to be offered.

Section III-5 Previous Florida Business History of Parent Company

In this section the parent company (if applicable) should detail any history that it has had in withdrawing from Florida as a whole or in discontinuing a particular line of business in this state.

Section III-6 Notification Statement to the NAIC

Applicant should provide a copy of the notification statement mailed to the NAIC (Official Form).

APPLICATION FOR CERTIFICATE OF AUTHORITY
DOMESTIC RECIPROCAL INSURER

SECTION IV - MANAGEMENT

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

Section IV-1

A listing of all members of the Subscribers Advisory Committee, officers, directors and shareholders of the Attorney-in-Fact, with their respective titles should be listed in this section. Please use attached form and list names in alphabetical order.

Section IV-2 Biographical Affidavits as to Subscriber Advisory Committee members, and Officers, Directors and Shareholders of the Attorney-in-Fact

A biographical affidavit (Form OIR-C1-1423) must be completed for each person listed in Section IV-1 if not on file and current with the Office. All questions must be answered and yes answers must be accompanied by an explanation. Each biographical affidavit must contain the original signature of the respective subscriber, officer, director or shareholder and an original notary seal.

The requirement for the affiant's social security number as part of the biographical affidavit is mandatory. However, pursuant to section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. 1 of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 6 of the NAIC form, please include the affiant's name and social security number on a separate page and attach it to the biographical affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

Section IV-3 Background Investigative Report

A Background Investigative Report must be provided for each person listed in Section IV-1 above. Background reports must be submitted by the selected background investigation vendor directly to the Office prior to or contemporaneously with the submission of the application filing. Attach confirmation that the reports have been ordered when submitting the application. Please refer to Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports.

Section IV-4 Fingerprint Cards

Fingerprint cards must be completed for each person listed in section IV-2 if not on file and current with the Office. The cards will be furnished by the Office upon request, either oral or written. **No cards other than those furnished by the Office will be acceptable.** These cards must be completed at a law enforcement or similar type agency and returned to this Office for processing. See Form OIR-C1-938 for instructions for ordering completing and submitting the fingerprint card.

APPLICATION FOR CERTIFICATE OF AUTHORITY
DOMESTIC RECIPROCAL INSURER

CHECK LIST
SECTION I – APPLICATION FORM AND FEE

Company Name: _____

Item #			Completion Check List
1.	Insurer application fees paid		☐
	(a)	Copy of invoice included	☐
	(b)	Copy of check	☐
2.	Fingerprint fees paid electronically		☐
	(a)	Copy of on-line payment confirmation	☐
3.	Company Completed Application for License (Official Form)		☐
	(a)	All classes of insurance to be transacted listed by code number	☐
	(b)	Sealed by Company	☐
	(c)	Signed by (original signatures)	
		1. Chairman of Subscribers Advisory Committee	☐
		2. Secretary	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
DOMESTIC RECIPROCAL INSURER

CHECK LIST
SECTION II - LEGAL

Company Name: _____

Item #			Completion Check List
1.		Consent and Agreement in re Service of Process	☐
	(a)	Signed by Chairman of Subscribers Advisory Committee	☐
	(b)	Signed by Secretary	☐
	(c)	Sealed with company seal	☐
	(d)	Original	☐
2.		Resolution Form	☐
	(a)	Signed by Chairman of Subscribers Advisory Committee	☐
	(b)	Signed by Secretary	☐
	(c)	Sealed with company seal	☐
	(d)	Original	☐
3.		Attorney-in-Fact Declaration	☐
	(a)	Signed by Attorney-in-Fact	☐
	(b)	Notarized	☐
	(c)	Original	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
DOMESTIC RECIPROCAL INSURER

CHECK LIST
SECTION II – LEGAL

(d) All items 1 thru 12 included..... ☐

4. Attorney-in-Fact Bond ..... ☐

(a) Copy of Bond included ($100,000 minimum)..... ☐

(b) Receipt for Deposit With the Office..... ☐

5. Secretary of State Registration (Attorney-in-Fact)

(a) Articles of Incorporation (certified originals)..... ☐

(b) Certificate of Status (original)..... ☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
DOMESTIC RECIPROCAL INSURER

CHECK LIST
SECTION III- FINANCIAL

Company Name: _____

Item #		Completion Check List
1.	Verification of Statutory Deposit.....	☐
	(a) Letter from Collateral Securities showing amount of deposit	☐
2.	Verification of Funds on Deposit.....	☐
	(a) Letter from financial institution showing:	
	(1) Amount of Deposit	☐
	(2) Name of Depositor.....	☐
	(3) Federal ID number.....	☐
	(4) Form of funds.....	☐
	(5) Account numbers.....	☐
	(6) Amount in each account.....	☐
	(7) Certificate of Deposit Numbers.....	☐
	(8) Certificate of Deposit maturity dates.....	☐
	(9) Any restrictions on withdrawals.....	☐
3.	Plan of Operations.....	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
DOMESTIC RECIPROCAL INSURER

CHECK LIST
SECTION III- FINANCIAL

Or

(a) Statement that no changes have been made ..... ☐

4. Statement of Method Used in Financing Insurer..... ☐

5. Previous Florida Business History Statement..... ☐

6. NAIC notification statement mailed directly to ☐
NAIC, copy included with filing..... ☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
DOMESTIC RECIPROCAL INSURER

CHECK LIST
SECTION IV- MANAGEMENT

Company Name: _____

Item #		Completion Check List
1.	Listing of all Subscribers Advisory Committee members, Officers, Directors and Shareholders of the Attorney-in-Fact (Official Form).....	☐
	(a) Full names listed	☐
	(b) Titles listed	☐
2.	Biographical affidavits as to Subscribers Advisory Committee members, officers and directors of the Attorney-in-Fact (Official Form)	☐
	As to each biographical:	
	(a) All blanks filled in.....	☐
	(b) Yes answers explained	☐
	(c) Contains original signature of each respective officer and director	☐
	(d) Notarized (Original).....	☐
3.	Background investigative reports for persons listed in Section IV-1.....	☐
4.	Fingerprint cards enclosed for each person listed in section IV-1 (If applicable).....	☐
	(a) Contains original signature of each respective officer, director or shareholder.....	☐
	(b) Office of Insurance Regulation card only	☐
	(c) No erasures or alterations on cards.....	☐
	(d) All blanks filled in.....	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
DOMESTIC RECIPROCAL INSURER

INVOICE

NAME OF COMPANY:_____

FEIN:_____

ADDRESS:_____

CITY, STATE & ZIP CODE:_____

PHONE NUMBER:_____

ADDRESS (IF DIFFERENT FROM COMPANY ADDRESS)

_____

_____

(CITY) (STATE) (ZIP CODE)

1. Make payable to the Florida Department of Financial Services and **mail check and invoice only** to the Florida Department of Financial Services, Bureau of Financial Services, 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.

TYPE: 10	CLASS: 30	Company License Tax	$1,000.00
TYPE: 10	CLASS: 06	Filing Fee	$1,500.00
		Total	$2,500.00

OFFICE OF INSURANCE REGULATION
TALLAHASSEE, FLORIDA 32399-0300

APPLICATION FOR LICENSE TO CONDUCT BUSINESS IN THE STATE OF FLORIDA
(Domestic Reciprocal Insurer)

_____, 20 ____

TO THE COMMISSIONER OF THE STATE OF FLORIDA,
TALLAHASSEE, FLORIDA

The_____
(Give name of company or association in full)

Federal Identification Number: _____

Of _____
(Home Office Address) (City) (State) (Zip)

Phone Number:_____

E-mail Address:_____

through its duly authorized officers, hereby applies for license authorizing and empowering the Company or Association aforesaid to transact the following kinds of insurance or branches of business in the State of Florida, under the laws thereof, during the year ending May 31, 20____.

Class of Business	Code Number

By: _____
Chairman Subscribers' Advisory Committee

Attest: _____
Secretary

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

Uniform Certificate of Authority Application
QUESTIONNAIRE

Directions: Each "Yes" or "No" question is to be answered by marking an "X" in the appropriate space. All questions should be answered. If the Applicant Company denotes a question as "Not Applicable" (N/A) an explanation must be provided. Other answers and additional explanations or details may be provided in writing attached to the questionnaire. Please complete this form and file it with the Applicant Company's application for a Certificate of Authority.

1. I hold the position(s) of _____ with the Applicant Company.

2. A. Has the Applicant Company transferred or encumbered any portion of its assets or business, or has its outstanding capital stock been directly or indirectly pledged?

   Yes ____ No ____

   B. Has the Applicant Company merged or consolidated with any other company within the last five years?

   Yes ____ No ____

   If the answer to either question is yes, provide the details in writing and attach to the Questionnaire.

3. Is the Applicant Company presently negotiating for or inviting negotiations for any transaction described above?

   Yes ____ No ____

   If yes, provide the details in writing and attach to the Questionnaire.

4. Has the Applicant Company ever changed its name?

   Yes ____ No ____

   If yes, attach copies of the instruments effecting such transaction certified by the Secretary over corporate seal as a true copy of the originals, including any official state regulatory approvals and filing data.

5. A. Has the Applicant Company undergone a change of management or control since the date of its latest annual statement filed in support of this application?

   Yes ____ No ____

   B. Does the Applicant Company contemplate a change in management or any transaction that would normally result in a change of management within the reasonably foreseeable future?

   Yes ____ No ____

   If the answer to either question is yes, provide the details in writing and attach to the Questionnaire.

6. Is the Applicant Company owned or controlled by a holding corporation?

   Yes ____ No ____

   If yes, attach and make a part hereof an affidavit by an executive officer of the Applicant Company who knows the facts listing the principal owners (10% or more of the outstanding shares) of such holding corporation by name and residence address, business occupation and business affiliations.

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

7. Is the Applicant Company owned, operated or controlled, directly or indirectly, by any other state or province, district, territory or nation or any governmental subdivision or agency?

Yes ____ No ____

If yes, provide the details in writing and attach to the Questionnaire

8. A. Has the Applicant Company's certificate of authority to do business in any state been suspended or revoked within the last ten years?

Yes ____ No ____

B. Has the Applicant Company's application for admission to any state been denied within the last ten years?

Yes ____ No____

If the answer to either question is yes, provide the details in writing and attach to the Questionnaire.

9. Has any person who is presently an officer or director of Applicant Company been convicted on, or pleaded guilty or nolo contendere to, an indictment or information in any jurisdiction charging a felony for theft, larceny or mail fraud or, of violating any corporate securities statute or any insurance statute?

Yes ____ No ____

If yes, provide the details in writing and attach to the Questionnaire.

10. Is the Applicant Company presently engaged in a dispute with any state of federal regulatory agency?

Yes ____ No____

If yes, provide the details in writing and attach to the Questionnaire.

11. Is the Applicant Company a plaintiff or defendant in any legal action other than one arising out of policy claims?

Yes ____ No____

If yes, provide a summary of each case and an estimate of the Applicant Company's probable liability, if any, and attach to the Questionnaire.

12. Does the Applicant Company purchase investment securities through any investment banking or brokerage house or firm from whom any of Applicant Company's officers, directors, trustees, investment committee members or controlling stockholders receive a commission on such purchases?

Yes____ No____

If yes, provide the details in writing and attach to the Questionnaire.

13. Is the Applicant Company a,

A. Bank

Yes ____ No ____

B. Bank holding company, subsidiary or affiliate

Yes ____ No ____

C. Financial holding company

Yes ____ No ____

D. Other financial institution

Yes ____ No ____

If yes, identify the bank(s), bank holding company(ies) or financial institution and the affiliation of the Applicant Company. Provide the details in writing and attach to the Questionnaire.

14. Has the Applicant Company, within 18 months last preceding the date of this affidavit, done any of the following:

A. Made a loan to an entity owned or controlled directly or through a holding corporation by one or more of Applicant Company's officers, directors, trustees or investment committee members, or to any such person?

Yes____ No____

B. Sold or transferred any of its assets or property, real or personal, to any such entity or person?

Yes____ No____

C. Had its outstanding capital stock directly or indirectly pledged for the debt of an affiliate?

Yes _____ No _____

D. Purchased securities, assets or property of any kind from an entity owned or controlled by one or more of the Applicant Company's officers, directors, trustees, or any persons who have authority in the management of the Applicant Company's funds (including a controlling stockholder)?

Yes ____ No____

If the answer to any of the last four questions is affirmative, did any officer, director, trustee or any person who had authority in the management of the Applicant Company's funds (including a controlling stockholder) receive any money or valuable thing for negotiating, procuring, recommending or aiding in such transaction?

Yes ____ No ____

If yes, provide the details in writing and attach to the Questionnaire.

15. Attach an organizational depiction (in the format of a flow chart) showing the various executive management, directors and officers and related material functions that require internal control oversight of the Applicant Company, with the name and official title of those responsible for those offices/functions and the portions of the organization they oversee. Material functions should include, but are not limited to, underwriting, claims adjustment/payments, premium accounting, claims accounting, marketing, financial reporting, and investment management. Note any executive or key staff that has access to funds or bank accounts. Submit a map or narrative explaining where offices are geographically located and the approximate number of employees at each location.

A. Designate any common facilities and/or any of the above functions that are shared with affiliates.

B. Designate any of the above office/functions that are delegated to third parties.

C. Attach copies of signed agreements for office functions delegated to either affiliates or third parties.

D. As applicable, attach a separate chart reflecting any other management positions (if different than what was noted above) that exercise control over insurance operations in other jurisdiction where the Applicant Company is seeking admission.

E. Attach any similar information that was submitted to lenders or investment partners.

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F. Attach a copy of the Applicant Company's investment policy (required for primary and redomestication applications only).

16. Provide a detailed description of the Applicant Company's sales techniques. The description should include:

A. Information regarding recruitment and training of sales representatives.

B. Identification as to whether the Applicant Company will be a direct writer or will use agents, brokers or a combination thereof.

C. Explanation of the compensation and control to be provided by the Applicant Company to its agents, brokers or sales personnel.

D. Sample copies of any agreements entered into between the Applicant Company and its agents or brokers.

E. If the Applicant Company will use a specific agency or managing general agent, identification of the agency or managing general agent and a copy of the agreement for this arrangement.

F. Sample contract forms of all types used and remuneration schedule, including those for general agents, if any.

17. For each state in which the Applicant Company is filing, explain:

A. The product lines currently sold or planned by the Applicant Company,

B. Specialty line or lines currently sold and planned,

C. Captive business,

D. The Applicant Company's marketing plan, including a description of the financial, corporate or other connections productive of insurance,

E. The Applicant Company's current and expected competition (both regionally and nationally), and

F. How each state in which admission has been requested fits into the marketing plan. General description of the classes to be transacted is not an adequate response. For example, if the Applicant Company plans to market credit life and disability products tailored for use by credit unions, simply stating that it will transact credit life and disability is inadequate.

18. If a parent, subsidiary and/or affiliated insurer is admitted for the classes of insurance requested in the pending application, please differentiate the products and/or markets of the Applicant Company from those of the admitted insurer(s).

19. Provide a detailed description of the advertising that will be used by the Applicant Company to market its products in each state. Include a detailed explanation as to how the Applicant Company will develop, purchase, control and supervise its advertising.

20. For each State, explain in detail the following:

A. How the Applicant Company's policies will be underwritten, including the issuance of policies and endorsements,

B. How policies will be cancelled,

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C. How premiums and other funds will be handled, and

D. How personnel will be trained, supervised, and compensated.

21. Explain in detail how the Applicant Company will adjust and pay claims.

A. Describe how the Applicant Company will train, supervise and compensate the personnel handling claims adjusting and claims payment.

B. Provide detailed information as to how and by whom claim reserves will be set and modified.

C. Does the Applicant Company pay any representative given discretion as to the settlement or adjustment of claims whether in direct negotiation with the claimant or in supervision of the person negotiating, a compensation which is in any way contingent upon the amount of settlement of such claims?

Yes ____ No ____

22. Is the Applicant Company a member of a group of companies that shares any of the following:

A. Common facilities with another company or companies

Yes ____ No ____

B. Services (e.g. accounting personnel for financial statement preparation)

Yes ____ No ____

C. Or, is a party to a tax allocation agreement in common with another company

Yes ____ No ____

If the answer to any of the above is yes, explain the division of costs between participants. If costs are pro-rated, what is the basis for division? Attach a copy of relevant contracts and include a summary of any attached contract.

23. Does the Applicant Company have any reinsurance contracts which contracts that in effect provide that Applicant Company will reimburse or indemnify the Reinsurer for losses payable there under?

Yes ____ No____

If yes, provide the details in writing and attach to the Questionnaire.

24. Does any salaried employee or officer, exclusive of a director, presently have in force a license as an insurance broker issued by the _____ Department of Insurance?
(Name of Application State)

Yes ____ No____

If yes, please identify his/her license and position held with applicant.

25. Does the Applicant Company have outstanding unexercised stock options?

Yes ____ No ____

A. If yes, to whom and in what number of shares?

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B. If options are outstanding for a number of shares greater than 10% of the number of shares presently issued and outstanding, a copy of the option form and of the plan pursuant to which they were granted are attached.

26. Are any of the Applicant Company's policies being sold in connection with a mutual fund or investment in securities?

Yes ____No____ Not Applicable ____

If yes, supply details including all sales literature which refers to the insurance and mutual fund or other investment literature that refers to the insurance and mutual fund or other investment plan connection.

27. If the Applicant Company is applying for authority to write Variable Annuities, provide the following:

A. Copy(ies) of any third-party management or service contracts

B. Commission schedules

C. Five-year sales and expense projections

D. A statement from the Applicant Company's actuary describing reserving procedures including the mortality and expense risks which the Applicant Company will bear under the contract

E. Statement of the investment policy of the separate account

F. Copy of the variable annuity prospectus as filed with the SEC unless the separate account is not required to file a registration under the federal securities law

G. Copies of the variable annuity laws and regulations of the state of domicile

H. Copy(ies) of the variable annuity contract(s) and application(s)

I. A description of any investment advisory services contemplated relating to Separate Accounts

J. Board of Directors resolution authorizing the creation of the separate account

28. If the Applicant Company is applying for authority to write Variable Life Insurance, provide the following:

A. Copy(ies) of variable life policy(ies) the Applicant Company intends to issue

B. Name and experience of person(s) or firm(s) proposed to supply consulting, investments, administrative, custodial or distribution services to the Applicant Company

C. Disclose whether each investment advisor i) is registered under the Investment Advisers Act of 1940, or ii) is an investment manager under the Employee Retirement Income Security Act of 1974, or iii) whether the Applicant Company will annually file required information and statements concerning each investment advisor as required by its domiciliary state

D. Copy of the variable life prospectus as filed with the SEC unless the separate account is not required to file a registration under the federal securities law

E. Statement of the investment policy of any separate account, and the procedures for changing such policy

F. Copies of the variable life insurance laws and regulations of the state of domicile

G. A statement from the Applicant Company's actuary describing reserving procedures including the mortality and expense risks which the Applicant Company will bear under the contract

H. Standards of suitability or conduct regarding sales to policyholders

I. Statement specifying the standards of conduct with respect to the purchase or sale of investments of separate accounts (i.e. Board resolution)

J. Board of Directors resolution authorizing the creation of the separate account

29. If the Applicant Company is applying for authority to write Life Insurance, has the Applicant Company at any time in any jurisdiction while operating under its present management, or at any time within the last five years irrespective of changes in management, taught or permitted its agents to sell insurance by using any of the following devices, or representations resembling any of the following:

A. "Centers of influence" and "advisory board,"

Yes____ No____

B. A charter or founder's policy,

Yes____ No____

C. A profit sharing plan,

Yes____ No____

D. Only a limited number of a certain policies will be sold in any given geographical area;

Yes____ No____

E. "Profits" will accrue or be derived from mortality savings, lapses and surrenders, investment earnings, savings in administration;

Yes____ No____

F. A printed list of several large American or Canadian insurers showing the dollar amounts of "savings", "profits" or "earnings" they have made in such categories.

Yes____ No____

If the answer to any of the above is yes, supply a complete set of all sales material including the sales manual, all Applicant Company instructional material, brochures, illustrations, diagrams, literature, "canned" sales talks, copies of the policies which are no longer in use, list of states where such methods were used and the date (by year) when they were used, the approximate amount of insurance originally written in each state on each policy form thusly sold, the amount currently in force, and the lapse ratio on each form year by year and cumulatively in gross to the present date.

30. Does the Applicant Company pay, directly or indirectly, any commission to any officer, director, actuary, medical director or any other physician charged with the duty of examining risks or applications?

Yes_____ No _____ Not Applicable____

If yes, provide the details in writing and attach to the Questionnaire.

The following questions are to be completed only if the Applicant Company is redomesticating to another state.

31. Does the Applicant Company have any permitted practices allowed by its current state of domicile?

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Yes_____ No _____ Not Applicable____

If yes, provide the details in writing and attach a copy of the state of domicile's approval to the Questionnaire.

32. Does the Applicant Company's current state of domicile prescribe any practices of the Applicant Company that are not in accordance with,

A. Laws, regulations or bulletins of proposed state of domicile;

Yes_____ No _____ Not Applicable____

If yes, provide the details in writing and attach to the Questionnaire.

B. Reserving requirements of proposed state of domicile; or

Yes_____ No _____ Not Applicable____

If yes, provide the details in writing and attach to the Questionnaire.

C. NAIC guidelines

Yes_____ No _____ Not Applicable____

If yes, provide the details in writing and attach to the Questionnaire.

33. Will the Applicant Company's investments comply with the investment laws, regulations or bulletins of the proposed state of domicile?

Yes_____ No _____ Not Applicable____

If no, provide the details in writing and attach to the Questionnaire.

34. Does the Applicant Company have any outstanding surplus notes?

Yes_____ No _____ Not Applicable____

If yes, provide the details in writing and attach to the Questionnaire and attach copy(ies) of the surplus notes reflecting the state of domicile's approval.

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UNIFORM CERTIFICATE OF AUTHORITY APPLICATION

FOR PRIMARY APPLICATION ONLY
FLORIDA SPECIFIC INFORMATION

1. Insurers are required to provide a copy of the Articles of Incorporation of any firm involved in the financing or formation of the insurer certified by the public official with whom the originals are on file in the state of domicile.

2. Florida requires a statement of the method to be used in the financing of the insurer and verification of funds. To print or download the items to be included (click here). There are additional financial requirements for mutual insurers. To print or download a copy of Section 628.161, Florida Statutes (click here).

3. For mutual insurers only, provide a copy of a fidelity bond or insurance policy per Section 628.171, Florida Statutes. To print or download a copy of Section 628.171, Florida Statutes (click here).

4. Florida requires fingerprinting of all individuals for which biographical affidavits or business character reports are being submitted. To print or download a copy of the fingerprint card instructions including instructions for submitting fingerprint fees (click here). The fingerprint cards can be obtained from the Applications Coordinator by calling (850) 413-2575 or email to appcoord@floir.com.

Office of Insurance Regulation
Company Admissions

APPLICATION FOR REGISTRATION AS A RISK PURCHASING GROUP

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.

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

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

APPLICATION FOR REGISTRATION AS A RISK PURCHASING GROUP

PURCHASING GROUP - NOTICE AND REGISTRATION CHECKLIST

NAME OF PURCHASING GROUP: _____

COMPLETION CHECKLIST

1. _____ Notice and Registration as a Purchasing Group form

   (a) ___ All information provided

   (b) ___ Signed by President or CEO and Secretary

   (c) ___ Notarized

2. _____ Service of Process Consent & Agreement

   (a) ____ Signed and dated by the President or CEO and Secretary

   (b) ____ Sealed by purchasing group (corporate seal)

   (c) ____ Signed by designee

   (d) ____ Original form with all information provided

3. _____ For purchasing groups domiciled in the state of Florida, Articles of Incorporation, Charter and Bylaws or other legal documents evidencing that the purchasing group has been duly organized and created, to include all amendments are submitted.

4. _____ For purchasing groups which collect premiums or pay claims, the following are submitted.

   (a) ____ Completed Biographical Affidavits, signed, dated and notarized.

   (b) ____ Letter requesting background investigative reports

   (c) ____ Completed Fingerprint cards

5. _____ Completed Check List returned with Purchasing Group – Notice and Registration

APPLICATION FOR REGISTRATION AS A RISK PURCHASING GROUP

PURCHASING GROUP - NOTICE AND REGISTRATION INSTRUCTIONS

1. Submit the Purchasing Group - Notice and Registration (official form enclosed). All questions must be answered. An original signature by the Purchasing Group's President or Chief Executive Officer and the Secretary must be notarized and appear on this form.

2. Submit the Service of Process document (official form enclosed)

3. For Purchasing Groups domiciled in the state of Florida, include a copy of the Purchasing Group's Articles of Incorporation, Charter and Bylaws or other legal documents evidencing that the purchasing group has been duly organized and created and all amendments thereto.

4. Florida Licensed Agents

   The Purchasing Group - The Notice and Registration must state the name, social security number, and license number of each of the Florida licensed agents of the purchasing group. Surplus lines agents should refer to Section 627.952(l)(b), Florida Statutes, for licensure and appointment requirements. For specific licensing and appointment requirements for Florida licensed agent(s) of purchasing groups, contact the Bureau of Agent and Agency Licensing at:
   http://www.myfloridacfo.com/Division/Agents/Licensure/default.htm

5. Purchasing Groups Using Admitted Insurance Carriers

   If the Purchasing Group intends to purchase liability insurance coverage from an insurance carrier admitted in the state of Florida, the insurance carrier is subject to the policy form and rate filing requirements of Sections 627.410 and 627.062, Florida Statutes. For questions regarding policy forms and rates, contact Property and Casualty Product Review at (850) 413-3146.

6. Purchasing Groups Using Eligible Surplus Lines Carriers

   Florida's Surplus Lines law will apply if the purchasing group intends to purchase liability insurance coverage from a Florida eligible surplus lines carrier. For specific guidelines regarding coverages eligible for export, refer to Section 626.916, Florida Statutes.

7. Background Requirements of Management

   For each officer, director, organizer, and administrator of the purchasing group whose duties of the purchasing group include premium collection or claims payments, background information shall be submitted as follows:

   (a) Biographical Statement and Affidavit (Form OIR C1-1423).

   A Biographical Affidavit must be completed for each individual indicated above. All

questions must be answered and yes answers must be accompanied by an explanation. Each Biographical Affidavit must contain an original signature of the respective officer or director and an 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 page 6 of the NAIC form, 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.

(b) Background Investigative Report

A Background Investigative Report must be provided for each person indicated above. Background reports must be submitted by the selected background investigation vendor directly to the Office prior to or contemporaneously with the submission of the application filing. Attach confirmation that the reports have been ordered when submitting the application. Please refer to Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports.

(c) Fingerprint Cards

Fingerprint cards must be completed for each person as indicated above. The fingerprint cards along with the fees are due at the time the application is filed. **No fingerprint cards, other than those furnished by the Office, will be accepted.** These cards must be completed at a law enforcement or similar type agency and returned to this Office for processing. Attach confirmation of fingerprint payment when submitting the application. Please refer to Form OIR-C1-938, Fingerprint Card Instructions. Additional cards are available upon request.

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, Fingerprint Card Instructions.

APPLICATION FOR REGISTRATION AS A RISK PURCHASING GROUP

PURCHASING GROUP - NOTICE AND REGISTRATION INSTRUCTIONS

Note: If all premiums are collected by the insurer(s) of the purchasing group, the background requirements should be omitted.

Any questions regarding the registration of purchasing groups in the State of Florida should be directed to the Applications Coordination Section at (850) 413-2575 or appcoord@floir.com.

You will receive written notification when the registration of the purchasing group is complete and the group has been added to the official list of registered purchasing groups. It is unlawful for a purchasing group to conduct or transact business in this state until the group is properly registered. The failure to comply with Florida's requirements regarding the registration and operation of a purchasing group in Florida shall subject you to the penalties set forth in Section 627.951, Florida Statutes. See Part XIX of Chapter 627, Florida Statutes and the applicable Florida Administrative Code Rules.

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 REGISTRATION AS A RISK PURCHASING GROUP

PURCHASING GROUP - NOTICE AND REGISTRATION

(All information must be typed or printed. Attach additional pages if necessary)

1. List the exact name of the Purchasing Group.

2. Indicate the form of organization (i.e. corporation, partnership, association, trust, etc.).

3. The Purchasing Group is domiciled in the State of:

4. The Federal Employers Identification Number (FEIN) of the Purchasing Group is:

5. List any other names under which the Purchasing Group is or may be doing business in this state or any other state, if different from above.

6. List the complete physical address of the Purchasing Group.

6b. List the complete mailing address of the Purchasing Group, if different from above.

7. List all other states in which the Purchasing Group is currently registered.

8. List the state in which the majority of the Purchasing Group's business, based upon the aggregate of premiums written, is being conducted.

APPLICATION FOR REGISTRATION AS A RISK PURCHASING GROUP

PURCHASING GROUP - NOTICE AND REGISTRATION

9. Give a general description of business or activities engaged in by the purchasing group members

_____

_____

_____

10. The Purchasing Group's membership will consist of (list specific examples of members, i.e., dentists, attorneys, etc.):

_____

_____

11. List the name, address, telephone number, and title of the contact person for the Purchasing Group who has knowledge of its insurance program, including membership criteria, coverages, and key personnel of the group's administrator and insurance carrier.

_____

_____

_____

12. List the name address, email, and telephone number of the firm that acts as the administrator of the Purchasing Group. (If none, answer none.)

_____

_____

_____

13. List the names, addresses, telephone number, and occupations of the principal officers and directors of the Purchasing Group.

Principal Officers	Principal Directors
_____	_____
_____	_____
_____	_____

14. The Purchasing Group intends to purchase the following lines and classifications of liability insurance:

_____

_____

15. The Purchasing Group intends to purchase the liability insurance described in item (14) above from the following insurance company or companies. Give full name of company, FEIN, and state of domicile.

NAME	FEIN	STATE OF DOMICILE
_____	_____	_____
_____	_____	_____
_____	_____	_____

APPLICATION FOR REGISTRATION AS A RISK PURCHASING GROUP

PURCHASING GROUP - NOTICE AND REGISTRATION

16. The names, social security numbers, and license numbers of Florida licensed agents (or social security numbers of those persons who will, in the near future, become Florida licensed agents) of the Purchasing Group are as follows:

Name	Social Security Number/License Number
_____	_____
_____	_____
_____	_____
_____	_____

17. Specify the method by which, and the person or persons, if any, through whom insurance will be offered to its member whose risks are resident or located in this state.

_____

_____

_____

18. Has any person transacting business on behalf of this Purchasing Group ever:

(A) been arrested, indicted, and/or convicted of a felony, or is a felony charge currently pending against any such person? _____

(B) been denied any application for a professional, vocational or business license? _____

(C) had suspended or revoked any such license? _____

(D) had withdrawn or surrendered any such application or license to avoid potential disciplinary action against licensee? _____

If the answer to any part of these questions is yes, attach a supplementary statement explaining in full each such occurrence.

I do hereby swear and affirm that the aforementioned statements and information are true and correct to the best of my knowledge.

_____
President or Chief Executive Officer Date

(Corporate Seal)

_____
Secretary Date

Sworn before me this
_____ day of _____ , 20___

Notary Public, State of _____ My Commission Expires____

Applicant Company Name: _____ NAIC No. _____

FEIN: _____

Uniform Certificate of Authority Application
CERTIFICATE OF DEPOSIT

I, _____ , _____
Name Title

for the State of _____ , hereby certify that _____
(Name of Applicant Company)

has on deposit through this office securities having par value of $_____ and/or a market value

of $_____held on _____ for the benefit of all
Date

_____ Policyholders or _____Policyholders and Creditors or _____Policyholders or Creditors in accordance with the laws

of this state. A listing of said securities is attached and made part of this Certificate. **

In witness whereof, I have hereunto set my hand and affixed the official seal of my office in

_____
City, State

this _____ day of _____, 20____.

_____
Signature

* Any state relying upon this deposit must notify the State completing this Certificate prior to granting the Applicant Company a Certificate of Authority. This Certificate does not guarantee the deposit balance subsequent to the aforementioned date as a result of the release of securities as authorized by this State.

** Listing should include a detailed description, including CUSIP number (if available), par value, and/or amortized value and/or market value for each security listed based on the information maintained by this state.

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Office of Insurance Regulation
Company Admissions

APPLICATION FOR REGISTRATION AS A RISK RETENTION GROUP

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.

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 REGISTRATION AS A RISK RETENTION GROUP

RISK RETENTION GROUP NOTIFICATION

This package has been developed to aid you in notifying the Office of Insurance Regulation (the Office) of your intention to act as a Risk Retention Group in Florida under the provisions of the 1986 Federal Liability Risk Retention Act (the Act) and applicable Florida Statutes.

In order to properly notify the Office, a Risk Retention Group must:

1. Complete and file the attached forms for Application for Registration as a Risk Retention Group and the Addendum To Registration as a Risk Retention Group. Please fill these forms out completely. Some of the information may have already been provided to us, but these forms are used by the Office for the quick retrieval of information and we ask that you assist us by entirely completing the forms;

2. Designate the Chief Financial Officer as the Risk Retention Group's agent for the purpose of receiving service of legal documents or process on the attached Appointment of Attorney to Accept Service, and the accompanying Resolution Form;

3. File a copy of the Risk Retention Group's charter showing that it has been organized primarily for the purpose of assuming and spreading all, or any portion, of the liability exposure of its group members;

4. File a certified copy of the Risk Retention Group's license issued by its state of domicile authorizing it to transact business as an insurance company;

5. File a copy of the plan of operation or feasibility study, which the Risk Retention Group has submitted to the insurance commissioner of its domicile state;

6. File the following:

   (a) A copy of the group's financial statements submitted to its state of domicile, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries.

   (b) A copy of each examination of the risk retention group as certified by the insurance commissioner of the public official conducting the examination.

   (c) A copy of any audit performed with respect to the risk retention group.

These notification documents must be submitted to the Office before the risk retention group offers insurance in Florida per Section 3(d)(2)(a) of the Act and Section 627.944 of the Florida Statutes.

Please note that Risk Retention Groups will be subject to premium taxes on their Florida business. See Section 627.944(3), of the Florida Statutes.

YOU WILL RECEIVE A WRITTEN RESPONSE THAT THE RISK RETENTION GROUP IS PROPERLY REGISTERED. The Risk Retention Group should not conduct or transact business in this state until it has been notified that its registration is complete. The penalties provided for a violation of the above requirements are set out in Florida Statues 627.951.

APPLICATION FOR REGISTRATION AS A RISK RETENTION GROUP

(All information should be typed)

1. List the Corporate name of the Risk Retention Group.

_____

(Name must include the phrase "Risk Retention Group")

List other names which the Risk Retention Group may be conducting business as; including d/b/a's.

_____

2. The primary activity of this Risk Retention Group consists of assuming and spreading all, or any portion, of the liability exposure of its members.

(Circle One) YES NO

3. The Risk Retention Group is organized for the primary purpose of conducting the activity described under (2) above.

(Circle One) YES NO

4. The Risk Retention Group is chartered and licensed as a liability insurance company under the laws of the State of _____, and is authorized to engage in the following lines of insurance under the laws of its chartering State:

_____
_____
_____
_____

5. The Risk Retention Group does not exclude any person from membership in the Group solely to provide for members of the Group a competitive advantage over such a person.

(Circle One) YES NO

6. Ownership of the Risk Retention Group consists of one of the following in accordance with Section 627.942(9)(e), F.S. (check one):

(a) _____the sole owners are all persons who comprise the membership of the group and who are provided insurance by the group; or

(b) _____ the sole owner of the Group is an organization which has as its members only persons who comprise the membership group, and its owners are only persons who comprise the membership of the group and who are provided insurance by the group.

7. This Risk Retention Group is comprised of members who are engaged in the following described business or activities, which are similar or related with respect to the liability to which such members are exposed by virtue of related, similar, or common business, trade, product, services, premises, or operations. Provide a detailed description of business or activities engaged in by group membership which coverage is provided (Attach additional page(s) if necessary):

_____
_____
_____
_____

APPLICATION FOR REGISTRATION AS A RISK RETENTION GROUP

8. List the name, address and telephone number of each officer/director of the Risk Retention Group and the key officer or staff person (not an employee of the group's management company) responsible for overseeing "hands on management" of the group. (Attach additional pages if necessary.):

_____

_____

_____

8A. List the name of the individual, address, and telephone number of the company responsible for management of the insurance operations of this Risk Retention Group. (If none, answer none.)

_____

_____

_____

_____

8B. List the name, address, and telephone number of the principal agent or broker responsible for marketing the group's insurance policies. (If none, answer none.)

_____

_____

_____

_____

9. The activities of the Risk Retention Group do not include the provision of insurance other than:

(a) liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its group members; and

(b) reinsurance with respect to the similar or related liability exposure of another Risk Retention Group (or a member of such other Risk Retention Group) engaged in business or activities which quality such other Risk Retention Group (or member) under item (6) above for membership in this group.

10. The Risk Retention Group will comply with the unfair claim settlement practices laws of this state.

(Circle One) YES NO

11. The Risk Retention Group will pay, on a non-discriminatory basis, applicable premium and other taxes which are levied on such group under the laws of this state.

(Circle One) YES NO

11A. List the name, address and phone number of the company or individual responsible for payment of these fees.

NAME ADDRESS PHONE NUMBER

_____

_____

_____

12. The Risk Retention Group has designated the Chief Financial Officer of this State to be its agent solely for the purpose of receiving service of legal documents or process.

(Circle One) YES NO

APPLICATION FOR REGISTRATION AS A RISK RETENTION GROUP

13. The Risk Retention Group will submit to examination by the Insurance Commissioner of this State to determine the Group's financial condition, if:

    (a) The Insurance Commissioner (Director, Superintendent) of the Group's domicile State has not begun or has refused to initiate an examination of the Group; and

    (b) any such examination by the Office of Insurance Regulation is coordinated so as to avoid unjustified duplication and unjustified repetition.

14. The Risk Retention Group will comply with a lawful order issued in a delinquency proceeding commenced by the Insurance Commissioner of this State upon a finding of financial impairment, or in a voluntary dissolution proceeding.

    (Circle One) YES NO

15. The Risk Retention Group will comply with the laws of Florida concerning deceptive, false or fraudulent acts or practices, including any injunctions regarding such conduct obtained from a court of competent jurisdiction.

    (Circle One) YES NO

16. The Risk Retention Group will comply with an injunction issued by a court of competent jurisdiction upon petition by the Insurance Commissioner of this State alleging that the Group is in hazardous financial condition or is financially impaired.

    (Circle One) YES NO

17. The Risk Retention Group will provide the following notice, in 10-point type, in any insurance policy issued by the Group:

    (Circle One) YES NO

NOTICE

This policy is issued by your Risk Retention Group. Your Risk Retention Group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your Risk Retention Group.

18. The Risk Retention Group has submitted to the Insurance Commissioner of this State, as part of this application and before it has offered any insurance in this state, a copy of the plan of operation or feasibility study which it has filed with the Insurance Commissioner (Director, Superintendent) of its chartering state. This plan or study discloses the name of the state in which the group is charted, as well as the group's principal place of business, and such plan or study further includes the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer. The group will promptly submit to the Insurance Commissioner of this State any revisions of such plan or study to reflect any changes to the plan including, but without limitation, additional lines of liability insurance which the group intends to offer, and any changes in the designation of the group's chartering state.

    (Circle One) YES NO

19. The Risk Retention Group will submit its annual financial statement to the Insurance Commissioner of this State by March 1st each year. The annual financial statement will be certified by an independent public accountant and include a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist.

    (Circle One) YES NO

APPLICATION FOR REGISTRATION AS A RISK RETENTION GROUP

20. The Risk Retention Group will not solicit or sell insurance to any person in this state who is not eligible for membership in the group.

(Circle One) YES NO

21. The Risk Retention Group will not solicit or sell insurance in this state, or otherwise operate in this state, if the group is financially impaired or is in a hazardous financial condition.

(Circle One) YES NO

We do hereby swear and affirm that the aforementioned statements and information are true and correct.

_____

President or Chief Executive Officer

(Corporate Seal)

_____

Secretary

Sworn before me this ____day of_____, 20 _____.

_____

NOTARY PUBLIC

STATE OF:
My commission Expires:

APPLICATION FOR REGISTRATION AS A RISK RETENTION GROUP ADDENDUM

To further notify the Office of Insurance Regulation of your intention to act as a Risk Retention Group in Florida under the provisions of the 1986 Federal Liability Risk Retention Act and applicable Florida Statutes, please respond to the following:

1. The Federal Identification Number of the Risk Retention Group is _____. (According to IRS Form SS-4 (Rev 4-91), The following must use FEIN's even if they do not have any employees: Trusts, Estates, Partnerships, Corporations, Nonprofit Organizations, and Plan Administrators.)

2. The name and social security numbers of Florida licensed agents (or those persons who will, in the near future, become Florida licensed agents) of the Group are as follows: (Use additional page if necessary.)

Name and address — Social Security Number

_____

_____

_____

3. The Group will participate, on a non-discriminatory basis, in any mechanism established or authorized under the laws of Florida for the equitable apportionment among insurers of liability insurance losses and expenses incurred on policies written through such mechanism.

We do hereby swear and affirm that the aforementioned statements and information are true and correct.

(Corporate Seal

_____
President or Chief Executive Officer — Date

_____
Secretary — Date

Sworn before me this _____day of_____, 20 _____.

_____
NOTARY PUBLIC

STATE OF:
My commission Expires:

APPLICATION FOR REGISTRATION AS A RISK RETENTION GROUP

NAME: _____

Completion
Check List

1. _____ Application for Registration as a Risk Retention Group

   (a) All questions (1-21) are answered completely and correctly

   (b) Registration signed and notarized

   (c) Addendum to Registration as a Risk Retention Group is answered completely and correctly and is signed and notarized

2. _____ Service of Process Documents

   (a) ___Appointment of Attorney to Accept Service is answered completely and correctly

   (b) ___Resolution Form; signed by President/CEO and Secretary with Corporate Seal Affixed

3. _____ Articles of Incorporation of the RRG showing that it has been organized primarily for the purpose of assuming and spreading all, or any portion, of the liability exposure of it's group members

4. _____ Certified copy of the RRG's Certificate of Authority license issued by it's state of domicile authorizing it to transact business as an insurance company (Not a photocopy. Must bear original seal of state of domicile.)

5. _____ Plan of Operation or feasibility study which the Risk Retention Group has submitted to the insurance commissioner of its domicile state

6. _____ Audited Financial Statement and Loss Reserve certification which the Risk Retention Group has submitted to the Insurance Commissioner (Director or Superintendent) of it's chartering state

7. _____ Completed Check List returned with Risk Retention Group Notification

RETURN THIS COMPLETED FORM WITH YOUR REGISTRATION

STATE OF FLORIDA

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPOINTMENT OF ATTORNEY TO ACCEPT SERVICE

The, _____a Risk Retention Group (called the Group) duly organized under the laws of the State of _____, appoints the Chief Financial Officer of the State of Florida, and his or her successors in office, to be its lawful attorney upon whom all legal process in any action or proceeding against it shall be served and further agrees that any lawful process against it which is served upon this attorney shall have the same legal validity as if served personally upon the Group.

The Group gives the Chief Financial Officer and his or her successors, full authority to do every act necessary to be done under this appointment as fully as the Group could do if personally present, and ratifies all that lawfully do under the power granted by this appointment. This authority may be withdrawn only upon a written notice of revocation and in any case shall continue in effect so long as any liability arising out of this appointment remains outstanding in the State. This instrument is executed pursuant to and shall be construed to constitute full compliance with Section 3(a)(1)(d) of the Liability Risk Retention Act of 1986.

The Group designates (_____) whose
(an individual)
address is (_____) and e-mail

is (_____) as the person to whom process against the Group served upon the Chief Financial Officer shall be forwarded.

IN WITNESS OF THIS APPOINTMENT, said Group, in pursuant to a resolution duly adopted by it's Board of Directors, has caused this instrument to be executed in this manner by its President and Secretary, and its corporate seal to be affixed at the City of _____, State of _____. This ___ day of _____, 20 ____.

Attest:

_____ _____
Secretary (Name of Risk Retention Group)

By

_____
(Corporate Seal) President

OIR-C1-144A
Rev. 5/17
Rule 69O-136.032

RESOLUTION FORM

I HEREBY CERTIFY that the following resolution was adopted by the entire Board or Directors of:

_____

_____

_____

_____

at a meeting held by the Board of Directors of the Company on this ____day of _____, 20__

"RESOLVED, that the President or Chief Executive Officer and Secretary of this corporation be and they are hereby authorized to execute, for and on behalf of this corporation, the attached Consent and Agreement in re Service of Process under the Laws of Florida."

_____

President/CEO Date

_____

Secretary Date

(Corporate Seal)

OIR-C1-514
REV 11/90
Rule 69O-136.032

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

Uniform Certificate of Authority Application (UCAA)
CERTIFICATE OF COMPLIANCE

State of _____ Office of _____
(Domiciliary State of Applicant Company) (Commissioner, Superintendent, Officer)

I, _____, hereby certify that I am the* _____,
(Name) (Position)

of the State of _____ and have supervision of insurance business in said State and as

such, I hereby certify that _____
(Name of Applicant Company)

of _____ is duly organized under the laws of said State and
(City/State)

is authorized to transact the business of _____
(Lines of Insurance)**

_____

_____

_____ insurance in this State.

IN TESTIMONY WHEREOF, I have hereunto set my hand at _____
(Location)

on this _____ day of _____, A.D. 20____
(Month)

_____ _____
(Signature) (Printed Name)

* Insurance Commissioner, Officer or Superintendent of Insurance authorized to certify to the insurance business within the domiciliary state.

** Lines of Insurance as shown on Form 3 of UCAA

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NAIC
National Association of Insurance Commissioners
www.naic.org

COMPANY CODE APPLICATION

NAIC COMPANY CODES ARE ONLY ASSIGNED TO *RISK-BEARING ENTITIES.*
(Agencies are not assigned NAIC company codes.)

YOUR APPLICATION *WILL NOT* BE PROCESSED UNLESS YOU HAVE BEEN ISSUED A CERTIFICATE OF AUTHORITY BY THE STATE INSURANCE DEPARTMENT IN WHICH YOU ARE DOMICILED AND REGULATED.

****A copy of your Certificate of Authority is required to process application. Attach to email or fax.****

FULL COMPANY NAME			
FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	STATE OF DOMICILE	DATE COMMENCED BUSINESS	DATE OF ORGANIZATION/INCORPORATION
MAIN ADMINISTRATIVE OFFICE ADDRESS			
CITY	STATE	ZIP	PHONE
CURRENT FINANCIAL STATEMENT CONTACT PERSON		EMAIL ADDRESS	
CURRENT FINANCIAL STATEMENT ADDRESS			
CITY	STATE	ZIP	PHONE
COMPANY PRESIDENT			

SELECT YOUR BUSINESS TYPE (As listed on your Certificate of Authority):

O Fraternal	O Life, Accident & Health	O Title
O Health	O Property & Casualty	O Other Risk-Bearing Entity

SELECT YOUR BUSINESS SUB-TYPE:

O Hospital, Medical, and Dental Service or Indemnity (HMDI)	O Prepaid Legal
O Health Maintenance Organization (HMO)	O Prepaid Dental
O Limited Health Services Organization (LHSO)	O Pre-Need Funeral
O ODS (Organized Delivery System)	O Motor Club
O MEWA (Multiple Employer Welfare Arrangement)	O None

SELECT YOUR COMPANY TYPE (How company is formed per Articles of Incorporation under Secretary of State):

O Stock	O Limited Liability Corporation	O Partnership (all types)
O Reciprocal	O U.S. Branch of Alien Insurer	O Proprietorship
O Fraternal	O Cooperative	O Syndicate
O Mutual	O Charitable Gift Annuity	O Other

SELECT YOUR COMPANY SUB-TYPE:

O Residual Market Mechanisms	O Captive – Pure	O City, Town, County, State, Parish, Township Mutual
O Risk Retention Group – Captive	O Captive – Other	O State Insurance Fund/Program
O Risk Retention Group – Traditional	O Captive – Special Purpose Financial Insurer	O None
O Special Purpose Vehicle	O Manager Managed Limited Liability Company	

TAX STATUS:

O Subject to IRS Tax	O IRS Tax Exempt (with exceptions)

Rev. 2/16

OIR-C1-1389
Rule 69O-136.011

WAS THIS COMPANY FORMED AS A RESULT OF SHELL OR ASSET PURCHASE?	O Yes O No
IS THIS COMPANY A BLUE CROSS BLUE SHIELD ASSOCIATION (BCBSA) MEMBER?	O Yes O No
IS THIS A U.S. BRANCH OF AN ALIEN INSURER? O Yes O No	If **YES**, what state is your port of Entry? _____

CHECK BELOW WHICH PERIOD YOU WILL BE SUBMITTING YOUR FIRST STATEMENT FILING TO THE NAIC:

O Annual O Quarter 1 O Quarter 2 O Quarter 3 YEAR_____ O Not Required

SELECT THE TYPE OF ANNUAL STATEMENT BLANK YOU WILL BE FILING:

O Combined Property & Casualty
O Individual Property & Casualty
O Life, Accident and Health
O Fraternal
O Health
O Title
O Not Required to File Financial Statements with the NAIC

If filing a **LIFE** or **FRATERNAL** statement, are there any separate accounts to report? If **YES**, please list the names below:

HOLDING COMPANY AND AFFILIATION REPORTING SECTION

HOLDING COMPANY SYSTEM STATUS:

O Part of an Ultimate Holding Company System O Not Part of an Ultimate Holding Company System

Is this company affiliated with or reported on another domestic Insurance entity's organizational chart? O Yes O No

A current copy of your Organizational Chart or Schedule Y is required with this application.

If **YES**, and a group code **HAS** already been established, please list below your group code and group name.

If **YES**, and a group code **HAS NOT** been established, a group code may be established for you. Please list below the affiliated domestic insurance companies, including their company codes.

If **NO**, affiliation could still be determined and a group code established. The NAIC will review your organizational chart and the Ultimate Controlling entity.

GROUP CODE	

LIST AFFILIATED COMPANIES AND COMPANY CODES

NAME AND TITLE OF PERSON COMPLETING THIS APPLICATION	EMAIL ADDRESS

Submit your application via email or fax. Once received, your new NAIC Company Code confirmation will be emailed within 4 business days to the Current Financial Statement Contact, as well as to the person completing this application, if different.

For additional questions:

Jennifer Heinz
Data Administrator III, Data Services
Direct Phone: **(816) 783-8605**
Fax: (816) 460-0131
Email: FDRCCREQ@NAIC.ORG

Cheryl Minor
Data Administrator III, Data Services
Direct Phone: **(816) 783-8608**
Fax: (816) 460-0131
Email: FDRCCREQ@NAIC.ORG

Application last updated: 2/29/2016

Office of Insurance Regulation
Company Admissions

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

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.

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

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

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

INSTRUCTIONS
SECTION I - APPLICATION FORM & FEES

Section I-1 Application Fees

Applicants must pay an application fee of $1,500 and a company license tax of $1,000. These fees are due at the time the application package is filed, and the filing fee is NON-REFUNDABLE.

Secure your check to the invoice (included in this package) and send to:

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

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

Section I-2 Fingerprint Fees

Applicants are required to prepay electronically for the processing of the fingerprint cards required in section IV-4. Please see Form OIR-C1-938 for instructions. The fingerprint cards are to be submitted at the time of the application filing.

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 to Conduct Business in the State of Florida

On this form, list the lines of insurance by code (see enclosed classifications and code number form, Form OIR-C1-1416, Uniform Certificate of Authority (UCAA) Lines of Insurance) you intend to write in the State of Florida. The lines of insurance listed must be consistent with the lines listed in the plan of operations submitted with this package. When a Certificate of Authority is issued by the Office of Insurance Regulation, it will include only those lines listed on this form and addressed in the pro formas in the plan of operations. It must be signed (original signatures) by both the President or Chief Executive Officer and the Secretary of the Fund.

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

SECTION II - LEGAL

THE OFFICE OF INSURANCE REGULATION RECOMMENDS THAT CORPORATE DOCUMENTS BE REVIEWED BY YOUR LEGAL COUNSEL. THE OFFICE IS A FILING AGENCY AND AS SUCH DOES NOT RENDER ANY LEGAL, ACCOUNTING OR TAX ADVICE. THE PROFESSIONAL ADVICE OF YOUR LEGAL COUNSEL TO ASCERTAIN EXACT COMPLIANCE WITH ALL STATUTORY REQUIREMENTS IS STRONGLY RECOMMENDED.

Section II-1 Service of Process Consent and Agreement

Provide an executed Uniform Consent to Service of Process, Form OIR-C1-1524.

Section II-2 Constitution, Bylaws and/or Trust Agreement

Submit an unexecuted copy of the proposed constitution, bylaws and/or trust agreement. The constitution, bylaws, or trust agreement shall contain a provision prohibiting any distribution of surplus or profit except to members of the Fund, as approved by the Office pursuant to Section 624.473, Florida Statutes.

Section II-3 Indemnity Agreement

Submit copies of properly executed indemnity agreements binding each Fund member to individual, several, and proportionate liability as set forth in Sections 624.472 and 624.474, Florida Statutes.

Section II-4 Sponsoring Organization

Submit the following documents from the sponsoring organization:

(a) Certified Articles of Incorporation as received from the Secretary of State (The Original).

(b) Certificate of Status from the Secretary of State (The Original).

(c) Certified copy of the bylaws or constitution signed, dated, and sealed by Secretary of the sponsoring organization.

(d) A brief history of the sponsoring organization including: the type of association or entity (trade association, professional association, industry association, or self insurance trust fund), the address and phone number of the sponsoring organization, the date the sponsor was incorporated, and whether or not the sponsor has been in continuous operation since the date of organization.

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

SECTION III - FINANCIAL

Section III-1 Statutory Deposit

Pursuant to Section 624.466 (9), Florida Statutes, a Commercial Self-Insurance Fund shall be required to file a statutory deposit with the Office for the protection of the insurer's policyholders and creditors. This deposit shall have at all times a value of not less than $100,000. In lieu of a deposit, a Fund may file with the Office a surety bond in a like amount.

Contact the Bureau of Collateral Management, Insurance Deposits Section, (850) 413-3164 for the procedures involved in establishing a deposit.

Include a verification from the Bureau of Collateral Management that the funds have been deposited or the surety bond.

Section III-2 Verification of Funds

At least 10 days prior to the proposed effective date of the issuance of any policy, the trustees shall submit proof that the members have paid into a common claims fund in a designated depository cash premiums in an amount not less than $50,000 or 10% of the estimated annual premium of the members at the inception, whichever is greater.

The funds must be verified by a letter from an officer of the financial institution where the funds are being held and should include the following:

1. Name of depositor and Federal ID Number.
2. Account numbers and amounts of funds in each account.
3. Form of funds on deposit.
4. Any restrictions on the withdrawal of the funds.

Section III-3 Plan of Operation

It is important for the Office to have a clear understanding of the proposed operations of the Fund and the goals it seeks to achieve. To meet this requirement, the Fund shall furnish a three-year Plan of Operations. If the applicant is owned or controlled by a Financial Institution as defined in Section 626.9885, Florida Statutes, please refer to restrictions outlined in this statute when developing the Plan of Operations. The plan must include all major areas of the proposed operations including but not limited to the following:

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

(A) A brief description of the management experience of each individual (by name) involved in the following areas: Marketing, Underwriting, Rating, Reserving, Reinsurance, Claims Handling, Accounting, Investments, and Managing General Agents.

(B) Description of each line of insurance products to be marketed and planned dates of initial marketing of each line.

(C) A three-year plan of marketing, including commission rates, use of brokering agents, third party administrators, and other administrative expenses.

(D) Provide planned use of reinsurance including the purpose of the reinsurance and the degree to which it is to be used in relation to the amount of insurance in force. Include copies of policies and agreements. These should detail retentions and limits of liability for the proposed reinsurance as well as catastrophe and coverage of the largest amount retained on one risk.

(E) Submit a statement regarding any planned changes in operations during the next three years. If no changes are planned, a statement to that effect.

(F) Provide a list of all assumptions used in projections and pro forma and disclose how these assumptions were derived. The assumptions should at least address how the premium levels have been derived, commission rates, investment income yields, expense levels, and benefits payable under accident and health policies and contracts.

(G) Provide pro forma financial statements utilizing Form OIR-DO-896, UCAA Proforma Financial Statements, Property and Casualty Insurance Company (NAIC UCAA Proforma Financial Statements, Form 13), available at: http://www.naic.org/industry_ucaa.htm, for three years, excluding any spreadsheet that requires Nationwide only data. Projections must be provided for each line of insurance proposed to be written. If you should have any questions concerning individual line items please refer to the NAIC instructions to the annual statement.

(H) Furnish a list of all consultant and expert services in use or proposed during the three-year period.

(I) Provide planned premium volume for Florida premium by line of insurance at three month intervals for a three-year period from initial marketing date for each line of insurance.

The Plan of Operation should also include a statement prepared by an actuary who is a member of the American Academy of Actuaries or the Casualty Actuarial Society establishing that the Fund has prepared a plan of operations which is based on sound actuarial principles.

Section III-4 Membership Applications

Submit a membership application for each member applying for coverage with the Fund. Each of the charter members must submit a completed application.

Section III-5 Financial Statements

Submit a current financial statement for each of the charter members of the Fund. Each of the charter members must submit a financial statement.

Section III-6 Previous Florida Business History of Parent Company

In this section the parent company (if applicable) should detail any history that it has had in withdrawing from Florida as a whole or in discontinuing a particular line of insurance in this state.

Section III-7 Fidelity Bond

Pursuant to Section 624.466(11), Florida Statutes, submit a bond (or insurance policy) in the amount of no less than 10% of the funds handled annually and issued in the name of the Fund covering its trustees, employees, administrator, or other individuals managing or handling the funds or assets of the Fund.

Section III-8 Contract Between Fund and Agent

Submit a complete copy of any proposed contracts between the Fund and any agent(s).

Section III-9 Administrators Agreement

Submit a complete copy of any proposed contract(s) or agreements between the Fund and the administrator.

Section III-10 Policies, Endorsements and Rates

You are not required to have your policy forms and rates approved as a condition precedent to receiving a Certificate of Authority. These forms and rates may be submitted any time after filing for the Certificate of Authority and **MUST** be approved prior to transacting any business. Submissions should be sent/linked to https://iportal.fldfs.com/ifile/default.asp

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

SECTION IV - MANAGEMENT

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

Section IV-1 Trustees and Administrator Listing

Submit Form OIR-C1-1298 listing the names of all trustees and officers/directors of the administrator and their relationship (owner, partner, officer, director, or employee) to the Fund. If the administrator is a partnership, then information should be submitted for all partners.

Section IV-2 Biographical Affidavits as to each Trustee of the Fund and each officer and director of the Administrator

A Biographical Affidavit, Form OIR-C1-1423 (NAIC Biographical Affidavit, Form 11), must be completed for each person listed in Section IV-1. All questions must be answered and yes answers must be accompanied by an explanation. Each Biographical Affidavit must contain the original signature of the respective trustee, officer, or director with an original notary seal.

The requirements for the affiant's social security as part of the Biographical Affidavit is mandatory. However, pursuant to Sections 119.0721(1) and (8), Florida Statutes, social security numbers collected by an agency are confidential and exempt from Section 119.07(1), Florida Statutes, and Section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 1 of the Biographical Affidavit, please include the affiant's name and social security on a separate page and attach it to the Biographical Affidavit. Also please mark CONFIDENTIAL at the top and bottom of the separate page.

Section 119.0721(8), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to 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 Background Investigative Report

A Background Investigative Report must be provided for each person listed in Section IV-1 above. Background reports must be submitted by the selected background investigation vendor directly to the Office prior to or contemporaneously with the submission of the application filing. Attach confirmation that the reports have been ordered when submitting the application. Please refer to Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports.

Section IV-4 Fingerprint Cards

Fingerprint cards must be completed for each person listed in section IV-1. The fingerprint cards along with the fees are due at the time the application is filed. **No fingerprint cards, other than those furnished by the Office, will be accepted.** These cards must be completed at a law enforcement or similar type agency and returned to this Office for processing. Attach confirmation of fingerprint payment when submitting the application. Please refer to Form OIR-C1-938, Fingerprint Card Instructions. Additional cards are available upon request.

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, Fingerprint Card Instructions.

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

CHECK LIST

SECTION I - APPLICATION FORM AND RELATED FEES

Fund Name: _____

Item #			Completion Check List
1.	Insurer application fees paid		☐
	(a)	Copy of invoice included	☐
	(b)	Copy of check	☐
2.	Fingerprint fees paid electronically		☐
	(a)	Copy of on-line payment confirmation	☐
3.	Company Completed Application for License (Official Form)		☐
	(a)	All classes of insurance to be transacted listed by code number	☐
	(b)	Sealed by Company	☐
	(c)	Signed by (original signatures)	
		1. Chairman of Board of Trustees	☐
		2. Secretary	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

SECTION II - LEGAL DOCUMENTS

Fund Name: _____

Item #		Completion Check List
1.	Uniform Consent to Service of Process (Form OIR-C1-1524)	☐
(a)	Signed by Chairman of Board of Trustees	☐
(b)	Signed by Secretary	☐
(c)	Sealed with company seal	☐
2.	Proposed Constitution/Bylaws	☐
(a)	Unexecuted	☐
(b)	Original	☐
3.	Indemnity Agreement	☐
(a)	Executed	☐
(b)	Originals	☐
4.	Sponsoring Organization Documents	
(a)	Articles of Incorporation (certified originals)	☐
(b)	Certificate of Status (original)	☐
(c)	Copy of Bylaws or Constitution	☐
(d)	Miscellaneous statements	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

SECTION III- FINANCIAL

Fund Name: _____

Item #			Completion Check List
1.	Verification of Statutory Deposit.....		☐
	(a)	Letter from Collateral Management showing amount of deposit.....	☐
2.	Verification of Funds on Deposit.....		☐
	(a)	Letter from financial institution showing:	
		(1) Amount of Deposit.....	☐
		(2) Name of Depositor	☐
		(3) Federal ID number	☐
		(4) Form of funds	☐
		(5) Account numbers	☐
		(6) Amount in each account.....	☐
		(7) Any restrictions on withdrawals.....	☐
3.	Plan of Operations		☐
4.	Membership Application for each member.....		☐
5.	Current Financial Statement for each member		☐
6.	Previous Florida Business History Statement		☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

SECTION III- FINANCIAL

Fund Name: _____

Item #		Completion Check List
7.	Copy of Fidelity Bond required in Section 624.466(11)	☐
8.	Copy of contract between Fund and Agent(s)	☐
9.	Administrators Agreement	☐
10.	Policies, Endorsements and Rates submitted as directed.....	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

SECTION IV- MANAGEMENT

Fund Name: _____

Item #		Completion Check List
1.	Listing of all Trustees of Fund and Officers/ Directors of Administrator (Form OIR-C1-1298)	☐
	(a) Full names listed	☐
	(b) Titles listed	☐
2.	Biographical affidavits as to Trustees of Fund, and Officers/ Directors of Administrator (Form OIR-C1-1423)	☐
	As to each biographical affidavit:	
	(a) All blanks filled in	☐
	(b) Yes answers explained	☐
	(c) Contains original signature of each respective officer, director or trustee	☐
	(d) Notarized (Original)	☐
	(e) Submitted original of each affidavit	☐
3.	Background investigative reports for persons listed in Section IV-1	☐
4.	Fingerprint cards for each person listed in Section IV-1	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

SECTION IV- MANAGEMENT

Fund Name: _____

Item #		Completion Check List
(a)	Contains original signature of each respective officer, director or trustee	☐
(b)	Office of Insurance Regulation card only	☐
(c)	No erasures or alterations on cards	☐
(d)	All blanks filled in	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

INVOICE

NAME OF FUND: _____

FEIN: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM FUND ADDRESS):

_____

_____
(CITY) (STATE) (ZIP CODE)

1. Make payable to the Florida Department of Financial Services and mail check and invoice only to the Department of Financial Services, Bureau of Financial Services, 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.

TYPE: 10	CLASS: 30	Company License Tax	$1,000.00
TYPE: 10	CLASS: 06	Filing Fee	$1,500.00
		Total	$2,500.00

OFFICE OF INSURANCE REGULATION
TALLAHASSEE, FLORIDA 32399-0300

APPLICATION FOR LICENSE TO CONDUCT BUSINESS IN THE STATE OF FLORIDA
(Commercial Self-Insurance Fund)

_____, 20____

TO: THE COMMISSIONER
OFFICE OF INSURANCE REGULATION
TALLAHASSEE, FLORIDA

The _____
(Name of Commercial Self-Insurance Fund)

Federal Identification Number _____

of _____
(Home Office Address) (City) (State) (Zip)

Phone Number _____

E-Mail Address _____

through its duly authorized officers, hereby applies for license authorizing and empowering the Commercial Self-Insurance Fund to transact the following lines of insurance in the State of Florida, under the laws thereof.

Line of Insurance	Code Number

By _____
Chairman Board of Trustees

Attest _____
Secretary

OIR-C1-845
Rev. 5/17
Rule 69O-136.011

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

Uniform Certificate of Authority Application (UCAA)
Expansion Application

To the Insurance Commissioner/Director/Superintendent of the State of:

(Check the appropriate states in which the Applicant Company is applying.)

Alabama		Montana	
Alaska		Nebraska	
Arizona		Nevada	
Arkansas		New Hampshire	
California		New Jersey	
Colorado		New Mexico	
District of Columbia		New York	
Connecticut		North Carolina	
Delaware		North Dakota	
Florida		Ohio	
Georgia		Oklahoma	
Hawaii		Oregon	
Idaho		Pennsylvania	
Illinois		Puerto Rico	
Indiana		Rhode Island	
Iowa		South Carolina	
Kansas		South Dakota	
Kentucky		Tennessee	
Louisiana		Texas	
Maine		Utah	
Maryland		Vermont	
Massachusetts		Virginia	
Michigan		Washington	
Minnesota		West Virginia	
Mississippi		Wisconsin	
Missouri		Wyoming	

The undersigned Applicant Company hereby certifies that the classes of insurance as indicated on the Lines of Insurance, Form 3, are all lines of business (a) currently authorized for transaction, (b) currently transacted, and (c) which the Applicant Company is applying to transact.

Name of Applicant Company: _____ NAIC No.: _____ -- _____
Group Code

Home Office Address: _____

Administrative Office Address: _____

Mailing Address: _____

Phone: _____ Fax: _____

Are these addresses the same as those shown on the Applicant Company's Annual Statement?

Yes ☐ No ☐

If not, indicate why: _____

© 2017 National Association of Insurance Commissioners

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

Date Incorporated: _____ Form of Organization: _____

Billing Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

Premium Tax Statement Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

Producer Licensing Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

Rate/Form Filing Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

Consumer Affairs Address: _____
E-Mail Address: _____ Phone: _____ Fax: _____

State or Country of Domicile: _____ Date Organized: _____

Date of Last Amendment of Charter, Bylaws or Subscriber's Agreement: _____

Date of Last Financial Examination: _____

Date of Last Market Conduct Examination: _____

Par Value of Issued Stock: $ _____ Surplus as regards policyholders: $ _____

Certificate of Deposit (Home State): $ _____

Ultimate Owner/Holding Company: _____

Has the Applicant Company ever been refused admission to this or any other state prior to the date of this application?

Yes ☐ No ☐

If yes, give full explanation in an attached letter.

Is Applicant Company a member of a group that is required to file an Own Risk Solvency Assessment (ORSA) report with your lead state?

Yes ☐ No ☐

Is the Applicant Company required to file an ORSA report with its lead state?

Yes ☐ No ☐

If yes to either ORSA question, please provide:

Lead State: _____ Lead State Contact Name: _____

E-mail Address _____ Phone: _____

The Applicant Company hereby designates (name natural persons only) _____ to appoint persons and entities to act as and to be licensed as agents in the State of _____, and to terminate the said appointments.

NOTE: This does not apply to those states that do not require appointments.

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

The following information is required of the individual (Applicant Company employee or paid consultant) who is authorized to represent the Applicant Company before the department

Name: _____

Title: _____

Mailing Address: _____

E-Mail Address: _____ Phone: _____ Fax: _____

Please provide a listing of all other applications filed by the Applicant Company, or any of its affiliates, that are pending before the Department.

_____

_____

Applicant Company Officers' Certification and Attestation

One of the three officers (listed below) of the Applicant Company must carefully read the following:

1. I hereby certify, under penalty of perjury, that I have read the application, that I am familiar with its contents, and that all of the information, including the attachments, submitted in this application is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license discipline or other administrative action and may subject me or the Applicant Company, or both, to civil or criminal penalties.
2. I acknowledge that I am familiar with the insurance laws and regulations of said state, accept the Constitution of such state, in which the Applicant Company is licensed or to which the Applicant Company is applying for licensure.
3. I acknowledge that I am the _____ of the Applicant Company, am authorized to execute and am executing this document on behalf of the Applicant Company.
4. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct, executed at _____.

_____ Date
_____ Signature of President
_____ Full Legal Name of President

_____ Date
_____ Signature of Secretary
_____ Full Legal Name of Secretary

_____ Date
_____ Signature of Treasurer
_____ Full Legal Name of Treasurer

_____ Name of Applicant Company

_____ Date
_____ Signature of Witness
_____ Full Legal Name of Witness

Applicant Company Name: _____ NAIC No. _____

FEIN: _____

Uniform Certificate of Authority Application (UCAA)
Expansion Application Checklist
For Expansion Application Only

The application checklist is intended to help guide the insurer (herein after referred to as "Applicant Company") with the assembly of a complete Expansion Uniform Certificate of Authority Application (UCAA). Please be sure to complete the checklist by appropriately marking the boxes on the left side of the page prior to submitting the application for review. The completed checklist should be attached to the top of the application.

Regulator Use Only

1. **Application Form and Supporting Documents, containing:** ☐
   - ☐ Completed UCAA Expansion Application Checklist (Form 1E)
   - ☐ Original UCAA Expansion Form executed and signed (Form 2E)
   - ☐ Include all lines of insurance the Applicant Company is licensed to transact, currently transacting and requesting authority to transact in all jurisdictions. (Form 3)
   - ☐ Notification to state of domicile of planned expansion
   - ☐ Cover letter (optional)

2. **Filing Fee (pursuant to Section II Filing Requirements Item 2), containing:** ☐
   - ☐ Payment of required filing fee
   - ☐ Copy of check

3. **Minimum Paid-in Capital and Surplus Requirements (pursuant to Section II Filing Requirements Item 3)** ☐
   - ☐ Provide explanation of compliance with minimum capital & surplus requirements for state for which application is prepared

4. **Certificate of Deposit for Statutory Deposit Requirements (pursuant to Section II Filing Requirements Item 4)** ☐
   - ☐ An original Certificate of Deposit prepared by state of domicile (Form 7)

5. **Name Approval (pursuant to Section II Filing Requirements Item 5)** ☐
   - ☐ Evidence of name approval request

6. **Plan of Operation (pursuant to Section II Filing Requirements Item 6)** ☐
   - ☐ Completed questionnaire (Form 8)
   - ☐ Pro Forma (Form 13)
   - ☐ Narrative

7. **Holding Company Act Filings (pursuant to Section II Filing Requirements Item 7)** ☐
   - ☐ Include Holding Company Act Filings, including Form B, Form F or substantially similar statement.

8. **Certificate of Compliance (pursuant to Section II Filing Requirements Item 8)** ☐
   - ☐ Original Certificate of Compliance (Form 6) completed by domiciliary state insurance regulatory agency

9. **Report of Examination (pursuant to Section II Filing Requirements Item 9)** ☐
   - ☐ Includes a copy of the most recent Report of Financial Examination from its domiciliary state and a note of all more recent examinations, completed by any state, including market conduct examinations along with a description of each examination.

10. **Statutory Membership(s)** ☐
    - ☐ Submit documentation as listed in Section II Filing Requirements Item 10

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Applicant Company Name: _____ NAIC No. _____

FEIN: _____

Regulator Use Only

11. **Public Records Package – Submit ALL items in chart in Section II Item 11, including:** ☐

a. **Articles of Incorporation, including:** ☐
   - ☐ Original certification by domiciliary state

b. **Bylaws, including:** ☐
   - ☐ Original certification by the Applicant Company's corporate assistant

c. **Statement with attachments, including:** ☐
   - ☐ Current year annual statement*, verified and signed, including actuarial opinion, and NAIC Management's Discussion and Analysis
   - ☐ Current year quarterly statements (one copy for each quarter), verified and signed

   *1. Updated statements should be submitted on a timely basis while application is pending.
   2. If annual statement for two preceding years has not been filed with the NAIC, one copy of each year must be submitted with the application.

d. **Independent CPA Audit Report** ☐

12. **NAIC Biographical Affidavit (Form 11) for the following:** ☐
   - ☐ Officers (as listed on Jurat Page of most recent financial statement)
   - ☐ Directors (as listed on Jurat Page of most recent financial statement)
   - ☐ Key managerial personnel (including any vice presidents or other individuals who will control the operations of the Applicant Company)
   - ☐ Individuals with a 10% or more beneficial ownership in the Applicant Company who will exercise control over the Applicant Company or, officers and directors of an entity with a 10% or more beneficial ownership in the Applicant Company who exercise control over the Applicant Company; and
   - ☐ Individuals with a 10% or more beneficial ownership in the Applicant Company's ultimate controlling person who will exercise control over the Applicant Company, and officers and directors of the ultimate controlling person who will control the operations of the Applicant Company
   - ☐ Affidavit originally signed and notarized within one year of application date
   - ☐ Affidavit certified by independent third party

13. **Uniform Consent to Service of Process** ☐
   - ☐ Original executed Service of Process form (Form 12)

14. **State-Specific Information** ☐
   - ☐ Check state-specific requirements for those states that require additional background information, such as fingerprints, in place of or in addition to Business Character Reports. If applying in one of those states, necessary fingerprint cards and processing fees should be included.

RESOLUTION FORM

I HEREBY CERTIFY that the following resolution was adopted by the entire Board or Directors of:

_____

_____

_____

_____

at a meeting held by the Board of Directors of the Company on this ____day of _____, 20__

"RESOLVED, that the President or Chief Executive Officer and Secretary of this corporation be and they are hereby authorized to execute, for and on behalf of this corporation, the attached Consent and Agreement in re Service of Process under the Laws of Florida."

_____

President/CEO Date

_____

Secretary Date

(Corporate Seal)

OIR-C1-514
REV 11/90
Rule 69O-136.032

NAIC
National Association of Insurance Commissioners

UCAA Instructions

2017

Revised as of December 12, 2016

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Rule 69O-136.011, 136.015, 136.034

Rev 12/16

NAIC
National Association of Insurance Commissioners

The NAIC is the authoritative source for insurance industry information. Our expert solutions support the efforts of regulators, insurers and researchers by providing detailed and comprehensive insurance information. The NAIC offers a wide range of publications in the following categories:

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Useful handbooks, compliance guides and reports on financial analysis, company licensing, state audit requirements and receiverships.

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Regulatory and industry guidance on market-related issues, including antifraud, product fi ling requirements, producer licensing and market analysis.

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Table of Contents

Page

Definitions 1

Primary Application 5

Expansion Application 19

Corporate Amendments Application 31

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UNIFORM CERTIFICATE OF AUTHORITY APPLICATION

COMPANY LICENSING DEFINITIONS

Admitted	The status of the Applicant Company once the state regulator has approved the UCAA application and issued a Certificate of Authority or an Amendment to a Certificate of Authority. An Applicant Company may be admitted in one or more states. The term admitted or licensed may be used interchangeably.
Alien Insurer	An insurer formed under the laws of a country or jurisdiction other than the United States of America, its states, districts, territories, and commonwealths.
Application	The form located on the UCAA website that the Applicant Company must submit with a UCAA application (including all attachments).
Application State	State in which the Applicant Company is applying.
Checklist	The form located on the UCAA website that provides a guide for assembling a complete application and that should be completed and attached to the top of a UCAA application.
Corporate Amendments Application	The type of UCAA application (including all attachments) that an existing insurer uses for requesting amendments to its Certificate of Authority.
Domestic Insurer	An insurer that is formed under the laws of the Domiciliary State.
Domiciliary State	The state where an insurer is incorporated or organized.
Duplicate Copy or Copy	A photocopy or reproduction that accurately reproduces the original.
Expansion Application	The type of UCAA application (including all attachments) that an existing insurer uses to apply for licensure in one or more additional Uniform States.
Filing Fee	The fee that a Uniform State charges for the processing of a UCAA application. The fee charged will vary by state and the Schedule of Fees is located on the UCAA website under the State Charts section.

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Foreign Insurer	An insurer formed under the laws of another state, district, territory or commonwealth of the United States.
Independent Third-Party	An Independent Third Party is one that has no affiliation with the Applicant Company and that is in the business of providing background investigations.
Key Persons in Control Functions	The decision-making individuals in control functions (that require internal control oversight of the Applicant Company) such as the heads of the risk management, compliance, internal audit and actuarial functions, as well as the appointed actuary if such person is not the head of the actuarial function, underwriting, claims adjustments/payments, financial reporting and investment management.
Lead State	Lead state(s) or designee assumes the role of coordinator and communication facilitator. The lead state(s) serves as the facilitator and central point of contact for purposes of gathering and distributing information to all regulators involved.
Licensed	An insurer that holds a valid Certificate of Authority that allows it to transact business in a state. One or more states may license an insurer. The term is also synonymous with Admitted.
NAIC Biographical Affidavit	The form, located in the UCAA Application Forms section, that the Applicant Company must submit for all officers, directors, and key managerial personnel of the Applicant Company; individuals with a 10 percent (10%) or more beneficial ownership in the Applicant Company; and individuals with a 10 percent (10%) or more beneficial ownership in the Applicant Company's ultimate controlling parent. The biographical affidavit must be current and the affiant must sign the affidavit not more than one year before the filing date of a UCAA application and certification by an Independent Third-Party.
Official Filing Date	The date the appropriate state regulator accepts a UCAA application for filing.
Original	The writing executed or issued by the person producing it. If electronically issued, "original" means the record created electronically, stored by electronic means. An electronic original may contain an electronic signature. A printout of an electronically created record that accurately reflects the electronic record may have the same effect as the original electronic record. An "original" or "wet" signature may be

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	required for certain documents, such as biographical affidavit and uniform consent to services of process forms. Check state-specific requirements.
Own Risk Solvency Assessment (ORSA)	An "Own Risk and Solvency Assessment" or "ORSA" shall mean a confidential internal assessment, appropriate to the nature, scale and complexity of an insurer or insurance group of the material and relevant risks associated with the insurer or insurance group's current business plan, and the sufficiency of capital resources to support those risks.
Plan of Operation	It is made up of three (3) components: a completed Questionnaire, a brief narrative that includes significant information not captured in the Questionnaire, and proforma Financial Statements. The Questionnaire and proforma Financial Statements are forms located on the UCAA website.
Primary Application	The type of UCAA application (including all attachments) filed in the state of domicile for use in licensing of a newly formed insurer or by an existing insurer that wishes to re-domesticate to another Uniform State.
Proforma Financial Statement	Financial projections for a three-year period. One of the three (3) components of a Plan of Operation. The form is located on the UCAA website in the UCAA Application Forms section.
Public Records Package	Contains certain items that accompany a UCAA application in order to satisfy the Public Records Act in some states. The requirements are located in the UCAA Application State Charts section.
Questionnaire	The form located on the UCAA website in the UCAA Application Forms that is a part of the Plan of Operation. The Applicant Company must submit a completed Questionnaire that is properly executed and notarized.
Senior Management	The body responsible for executing decisions made by the Board and for managing the Applicant Company on a day-to-day basis, including any officer and/or director listed on the Jurat page of the most recent annual/quarterly financial statement.
State Charts	Charts that display the state-specific information. These charts are located on the UCAA website.

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State-Specific Information	The additional information that is required by a state before it can grant approval of a UCAA application. The requirements are located in the State Charts section on the UCAA website.
Statutory Home Office Address	As identified with the Certificate of Authority in domiciled state. (This definition is consistent with the Annual Statement Instructions.)
UCAA	Uniform Certificate of Authority Application.
UCAA Website	http://www.naic.org/industry_ucaa.htm
Uniform State	A state that is committed to using the UCAA review process for licensing and admissions of insurers.
Updates/Changes	Update is the requirement that an Applicant Company continue to update its filing with current documents. Changes are significant changes that occur or that a state discovers during a UCAA application review period, including any changes that materially affect the accuracy of the forms filed in support of a UCAA application.

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UNIFORM CERTIFICATE OF AUTHORITY APPLICATION

PRIMARY APPLICATION

The ALERT Subgroup designed the Primary Application to the Uniform Certificate of Authority Application (UCAA) for use in the formation of a new insurer, or for an existing insurer to use in making application to redomesticate to another state. A Uniform State is one that is committed to using the UCAA review process for company licensing and admissions.

The following pages contain detailed explanations of the various licensing requirements, along with instructions designed to assist with preparing and submitting the necessary documentation. Each state's review process may follow slightly different time lines to complete a comprehensive and detailed operational and financial review of the Applicant Company's business. It is the goal of all Uniform States to complete their review of Primary Applications within 90 calendar days of receipt. The 90-day review process includes two weeks to determine if the application is complete and acceptable for filing. During the remaining time-span, the application will receive a financial and operational review. A state may not achieve the 90-day processing goal in instances where substantial follow-up is required or in states with limited resources, or in instances when the Applicant Company files an application during peak business periods such as year-end and annual statement filing periods.

Based on the circumstances of a particular application, it may be necessary for the reviewing state to request additional information. Typically, a state will request any additional information that it needs within 30 days after the state accepts the application.

The UCAA Primary Application has four sections designed to guide the Applicant Company through the licensing process:

I. Application Review Process
II. Filing Requirements (New Insurers and Redomestications)
III. Filing Requirements (Redomestications Only)
IV. How to File

The goal of the UCAA is to provide a streamlined approval process. However, some states have state-specific filing requirements based on either statutory requirements or internal procedures. The uniform states are working to eliminate non-essential state-specific requirements. All Applicant Companies must be familiar with the insurance laws of the state to which they submit an application. Please see the UCAA website for information related to obtaining a copy of the laws, regulations and bulletins for the state in which an application is filed.

If the Applicant Company has any questions about the uniform admission process, a list of contact names, addresses and telephone numbers is provided on the Addresses and Contacts for Submission of Application chart. It is highly recommended that the Applicant Company contact each state with any questions before submitting the application for review.

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Primary Application Section I
Application Review Process

The ALERT Subgroup designed the Primary Application of the UCAA to provide a uniform process for the formation of a new insurer. An existing insurer that desires to redomesticate to another state should also use this application package. Existing insurers that wish to gain admission in additional states should file the Expansion Application of the UCAA. It is the goal of each Uniform State to process all Primary applications within 90 calendar days of receipt. The 90-day review process includes two weeks to determine if the application is complete and acceptable for filing. During the remaining time-span, the application will receive a financial and operational review. A state may not achieve the 90-day processing goal in instances where the application requires substantial follow-up, or in states with limited resources, or in instances when the Applicant Company files an application during peak business periods such as year-end and annual statement filing periods.

Based on the circumstances of a particular application, it may be necessary for the reviewing state to request additional information. Typically, a state will request any additional information it needs within 30 days after the state accepts the application.

Proprietary Information

Both regulators and the Applicant Company should note that the Applicant Company might deem confidential any communications with insurance regulatory agencies in conjunction with the Primary Application concerning proprietary information about the Applicant Company. States may only share information determined to be confidential with other persons as authorized by law. By law, the state will not disclose to the public any information determined to be proprietary and trade secret. Each Applicant Company needs to expressly identify all information, in the application and in any subsequent correspondence, that the Applicant Company considers proprietary or trade secret.

The UCAA website explains the requirements and filing process for the Primary Application. Please do not hesitate to contact the appropriate state regulators with any questions before filing any Uniform Application.

Step One: Filing An Application
Processing Goal: 2 Weeks

The Applicant Company may submit Primary Applications anytime during the year. The state immediately reviews Primary Applications to ensure that the Applicant Company submitted the application in the required format as outlined in these instructions.

Generally, within two weeks from the date the state receives the application, the state will notify the Applicant Company whether or not the state has accepted the application for filing. If the state accepts the application for filing, it will assign an official filing date.

If the state does not accept the application for filing due to a deficiency in the application's format, the state will contact the Applicant Company. Depending upon the nature of the deficiency, the state may give the Applicant Company two weeks from the date of receipt of notification from the department reviewing the application to correct the deficiency. Some states may return to the Applicant Company any applications that are deficient and not accepted for filing.

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Step Two: Application Review
Processing Goal: 90 Days

A Primary Application will undergo a rigorous financial and operational review in the state to which the Applicant Company submitted the application. While the goal of each state is to complete this review in 90 days, the states cannot guarantee review within this period. Due to varying levels of resources available in each state, a substantive review of the Primary Application may take longer than 90 days in some cases. Furthermore, if the state needs additional information to complete a substantive review of an application, the review may also take longer to complete. Once the state requests additional information, the state suspends the 90-day goal until it receives the requested information. The purpose of the Primary Application is to streamline application processing and the state will make every effort to process a Primary Application as quickly as possible.

At the conclusion of the substantive review by the reviewing state, the state will grant the Applicant Company a Certificate of Authority as a domestic company, allow the Applicant Company to withdraw the application, or will deny the application.

If the application is denied, the state will notify the Applicant Company and provide a detailed explanation for the denial. After the denial, if the Applicant Company wishes to re-file a Primary Application, the state will require a new application and filing fee.

Primary Application Section II
Filing Requirements (New Insurers and Redomestications)

This section provides a guide to understanding the focus of each document of the Primary Application. However, the application typically uses the documents for multiple purposes. Therefore, it is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents, although generally no more than five (5) years old. Please contact the states individually if there are questions about a specific document.

All forms required for the Primary Application are available on the UCAA website under the Primary Application tab and UCAA Forms and the Applicant Company can download these documents for printing and submission.

Table of Contents

1. Application Form and Attachments
2. Filing Fee
3. Minimum Capital and Surplus Requirements
4. Statutory Deposit Requirements
5. Name Approval
6. Plan of Operation
7. Holding Company Act Filings
8. Statutory Membership(s)
9. SEC Filings or Consolidated GAAP Financial Statement
10. Debt-to-Equity Ratio Statement

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11. Custody Agreements
12. Public Records Package
13. NAIC Biographical Affidavits
14. State-Specific Information

1. Application Form and Attachments

The application must identify all lines of insurance the Applicant Company is requesting authority to transact, as identified by the Applicant Company's plan of operation. Only the Applicant Company using this application for a redomestication filing need to complete the section listing the lines of business that the Applicant Company is currently licensed to transact and is transacting in all jurisdictions. Submit a completed checklist (Form 1P) and original executed application form (Form 2P and Form 3) as Item 1 of the application.

2. Filing Fee

The application must include a filing fee for the state in which an application is being submitted. The payee name and the instructions for submitting the filing fee are included in the Filing Fees - Primary and Expansion Applications chart located on the UCAA website. Submit a copy of the Applicant Company's check as Item 2 of the application.

3. Minimum Capital and Surplus Requirements

The application must show that the Applicant Company meets the state's statutory minimum capital and surplus requirements. In some states, the minimum capital and surplus requirements are determined by the classes of insurance that the Applicant Company is requesting authority to transact and the classes of insurance the Applicant Company is authorized to transact in all other jurisdictions. The state will determine the level of surplus required after considering the Applicant Company's product line, operating record and financial condition. Compliance with the statutorily prescribed minimum surplus requirement may not be sufficient for all applicants. The UCAA website contains a chart that identifies the Minimum Capital and Surplus Requirements for each Uniform State. It also provides a contact person or a link to a state-specific format or RBC requirements and instructions. Submit an explanation of the Applicant Company's compliance with the capital and surplus requirements as Item 3 of the application.

4. Statutory Deposit Requirements

The domiciliary state may require a statutory deposit. The Statutory Deposit Requirements chart located on the UCAA website provides state-specific requirements and identifies those states that require a Statutory Deposit. Submit as Item 4 of the Application, documentation explaining how the Applicant Company meets or is meeting the statutory deposit requirements. Unless otherwise indicated, the Statutory Deposit is for the benefit of all policyholders.

5. Name Approval

Each state has different guidelines and procedures for name approval. The Name Approval Requirements chart located on the UCAA website is intended to serve as a guide for the various name approval requirements of each Uniform State. The Applicant Company should check with

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the state to ensure compliance with all applicable name approval requirements. Where applicable, submit evidence of name approval request as Item 5 of the application.

6. Plan of Operation

The plan of operation has three components, a brief narrative, proforma financial statements/projections and a completed Questionnaire (Form 8). The narrative should include significant information not captured as part of the Questionnaire that the Applicant Company submits in support of the application, such as the reason for redomestication. The proforma is one of the three (3) components in the Plan of Operation. The forms are located on the UCAA website under the Primary Application tab. There is a proforma for Life, Property/Casualty, Health and Title companies. Provide a company-wide, three-year proforma balance sheet and income statement. The proforma workbook should be the same business type as the financial statement blank filed with the NAIC. For the lines requested, provide three-year premium and loss projections by line for the application state. Projections must support all aspects of the proposed plan of operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections.

The proforma when applied to the primary application is projected data. As such, the projected amounts need not balance with historical NAIC financial filings. The projected data, however, should be relevant to the Applicant Company's history of growth and losses as contemplated by the NAIC *Accounting Practices and Procedures Manual*.

The proforma should be completed by statutory accounting or financial reporting professionals that should be available to answer any questions or concerns from reviewing regulatory staff. The proforma is completed on an annual basis, typically for a three year time period, however, some states may require five years. The proforma should start with the first full year of operation that the Applicant Company anticipates actively writing business in the state(s) receiving the application.

Submit the completed Questionnaire and all attachments as Item 6 of the application.

7. Holding Company Act Filings

If the Applicant Company is a member of a holding company system, the application must include either the most recent Holding Company Act (HCA) filings, including the Annual Form B Registration Statement and related Form F or a statement substantially similar to the NAIC *Insurance Holding Company System Regulatory Act* (#440) The filing should include all attachments, exhibits and appendices referenced in the HCA filings. Submit the HCA filings as Item 7 of the application, include all attachments and any amendments up to the application filing date and include copies of all advisory, management and service agreements.

8. Statutory Memberships

In some states, the Applicant Company is required to join one or more rating, guarantee or other organizations before transacting insurance. Generally, the Applicant Company's authorized lines of insurance govern statutorily mandated memberships. The Statutory Membership Requirements chart is located on the UCAA website. Inquire with the licensure state about any

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required statutory memberships before transacting insurance. Submit documentation supporting membership application(s) as indicated, in states where required, as Item 8 of the application.

9. SEC Filings or Consolidated GAAP Financial Statement

If the Applicant Company, its parent or its ultimate holding company has made a filing or registration with the U.S. Securities and Exchange Commission (SEC) in connection with a public offering within the last three years, or filed an 8K, 10K or 10Q within the last 12 months, the application must note that the filing, including any supplements or amendments, is available electronically from the SEC. If the Applicant Company, its parent or its ultimate holding company is not publicly traded, the application must include a copy of the Applicant Company's most recent Consolidated GAAP financial statement. Submit the notice of SEC filings or copy of a Consolidated GAAP statement as Item 9 of the application.

10. Debt-to-Equity Ratio Statement

Members of a holding company system must submit debt-to-equity information as Item 10 of the application. The application must include a comprehensive debt-to-equity ratio statement that includes the following information.

A. Provide the consolidated outside debt to consolidated equity ratio on a GAAP basis for the holding company. *

Debt Duration	Debt Amount ($)	Debt to Consolidated Equity Ratio
Up to 5 years		
Up to 10 years		
Up to 20 years		

B. Provide the most recent consolidated holding company financial statement.

C. State if the holding company, on a consolidated basis, has a tangible net worth: a) for the past three years; b) at present; and c) provide projections with assumptions for a three-year period.

D. The Applicant Company must clearly substantiate the sources of repayment of any debt, including, but not limited to, whether the source of repayment is independent from the future income of the insurers.

E. Calculate the debt service (as reported in D above) required of each insurer as a percentage of the Applicant Company's capital and surplus.

F. List the assets of the holding company, if any, that are pledged to fund the debt service or debt repayment of an affiliate or parent (include the assets or stock of any insurer subsidiaries)

G. List any guarantees (personal or otherwise) from the shareholders for repayment of the debt.

*Some states may require re-statement based upon statutory equity.

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11. Custody Agreements

The Applicant Company should include a statement setting forth whether or not any of the Applicant Company's stocks, bonds, or other physical or book entry securities are in the physical possession of another entity.

If any of the Applicant Company's stocks, bonds or other securities are not in the Applicant Company's actual physical possession or in a safe deposit box under the exclusive control of the Applicant Company (except as shown in the Schedule of Special Deposits in the Applicant Company's Annual Statement), the application must include the written agreement with each entity holding and/or administering these securities. The written agreement should include appropriate safeguards for the handling of the securities, in accordance with those specified in the NAIC *Financial Condition Examiners Handbook* (Handbook).

Some states have additional requirements for these custody agreements, beyond those called for in the Handbook. Submit the statement and copies of the custody agreements as Item 11 of the application.

12. Public Records Package

Most states have requirements to disclose information to the public under a Public Records Act. To meet these public disclosure requirements certain items must accompany the application. While these documents may or may not be part of the substantive review, please be sure to include the required documents with the application. Please see the Public Records Package chart on the UCAA website for each state's document list. The chart contains requirements for financial and operational filings. An Applicant Company seeking to redomesticate should provide both financial and operational documents for the application state. An Applicant Company that is seeking to form a new insurer should include all documents listed in the operational section of the chart for the application state. Submit all documents required by the application state as Item 12 of the application.

13. NAIC Biographical Affidavit (Biographical Affidavit)

A. The Applicant Company is required to submit an NAIC Biographical Affidavit in connection with pending or future application(s) for licensure or a permit to organize with a department of insurance in one or more states. The Applicant Company must submit an NAIC Biographical Affidavit on behalf of all officers, directors and key managerial personnel of the Applicant Company and individuals with a ten percent (10%), or more, beneficial ownership in the Applicant Company and the Applicant Company's ultimate controlling parent ("Affiant").

B. The UCAA defines "Independent Third-Party" as:

(i) A consumer reporting agency ("CRA") overseen by the Federal Trade Commission ("FTC") and, therefore, subject to the FCRA, which have been vetted and is currently on the approved list;

(ii) Has the ability to perform international background investigations; and

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(iii) One whose officers and directors have no material affiliation with the Applicant Company other than stock ownership amounting to less than one percent (1%) of total stock outstanding, unless prior approval is given by the department of insurance to which application is being made.

C. The NAIC Biographical Affidavit requests information with respect to your employment history, education, personal information and character. The NAIC Biographical Affidavit also includes the Disclosure and Authorization Concerning Background Reports (the "Disclosure & Authorization Form"). The signature of the Affiant on the Disclosure & Authorization Form permits an Independent Third-Party to conduct a independent third-party verification on the Affiant.

D. The NAIC Biographical Affidavit includes three types of the Disclosure & Authorization Form. There are three different Disclosure & Authorization Forms since certain state laws, regulations and rules require different kinds of disclosures and wording within such form. An Affiant must sign the corresponding Disclosure & Authorization Form(s) for the respective state(s) where the affiant has lived or worked within the last ten (10) years. Refer to the Disclosure & Authorization Forms for further information.

E. The NAIC Biographical Affidavit is used to evaluate the suitability, competency, character and integrity of the Affiant in connection with an Applicant Company's pending or future application(s) for licensure or a permit to organize with a department of insurance in one or more states.

The Independent Third-Party uses information contained in the NAIC Biographical Affidavit as a tool to perform an independent third-party verification to determine an individual's fitness and propriety. The independent third-party verification may contain information bearing on the Affiant's character, general reputation, personal characteristics, mode of living and credit standing (if required by the state). The Independent Third-Party Vendor shall use the independent third-party verification to create a background report (the "Background Report").

F. The Disclosure & Authorization Form is valid for a maximum of one year. Additionally, an Affiant may revoke the authorization at any time by delivering a written revocation to the Applicant Company. Refer to the Disclosure & Authorization Form for further information.

G. The Background Reports are subject to the Fair Credit Reporting Act ("FCRA"). Pursuant to FCRA, the state departments of insurance and an Applicant Company who is seeking admission are "users" of consumer reports. The FCRA requires that the Applicant Company provide the Affiant with a copy of the "Summary of Your Rights Under the Fair Credit Reporting Act." The Applicant Company should provide a copy of the "Summary of Your Rights under the Fair Credit Reporting Act" to each Affiant. This summary can be found at the Federal Trade Commission ("FTC") website.

H. The Applicant Company and state departments of insurance are required to comply with FCRA, especially as it relates to confidentiality of the information contained in such consumer reports. To the extent required by law, the states and Independent Third-Party

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Vendors should maintain the Background Reports procured under the Disclosure & Authorization Form as confidential. A copy of the FCRA is located here.

I. The department of insurance in the state where an Applicant Company files, or intends to file, an application and the Applicant Company may require the Background Report. An Affiant who desires a copy of their Background Report may request a copy from the Applicant Company or the CRA as indicated on the Disclosure & Authorization Form. Refer to the Disclosure & Authorization Form for further information.

J. Please check state requirements for those states that require additional background information, such as fingerprints, in place of, or in addition to, NAIC Biographical Affidavits. If applying in one of those states, necessary fingerprints and processing fees should be included.

Refer to the UCAA website for a list of currently approved Independent Third-Party Vendors for Background Reports.

NAIC Biographical Affidavits must be completed on the most **current form** [Word | PDF], in effect at the time the affidavit was signed and the affiant shall not sign the Affidavits more than one year before the date the Applicant Company files the application.

Submit original Biographical Affidavits (Form 11) that contain the Disclosure & Authorization Forms to the state department(s) of insurance as Item 13 of the application.

14. State-Specific Information

Some jurisdictions may have additional requirements before a Certificate of Authority is issued. Before completing a UCAA Primary Application, the Applicant Company should review the list of requirements for the application state. State-specific requirements are listed on the UCAA website. Submit state-specific requirements as Item 14 of the application.

Primary Application Section III
Filing Requirements – Redomestications Only

The requirements of this section are only for those Applicant Company's seeking to redomesticate from one state to another and are in addition to the requirements of Section II, Items 1 through 14 of the Primary Application. A redomestication is the process whereby any insurer organized under the laws of any state may become a domestic insurer that transfers its domicile to another state by merger or consolidation or any other lawful method. The Applicant Company files the Primary Application with the Applicant Company's new state of domicile when used for a redomestication.

Table of Contents

15. Annual Statements with Attachments
16. Quarterly Financial Statements
17. Risk-Based Capital Report
18. Independent CPA Audit Report
19. Reports of Examination
20. Certificate of Compliance

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15. Annual Statement with Attachments

Include a copy of the Applicant Company's most recent annual statement as filed in the current state of domicile including all statements and supplements in accordance with the *Annual Statement Instructions*, including the Statement of Actuarial Opinion and Management's Discussion and Analysis. The annual statement should be signed and verified, and include an original certification from the state insurance regulatory agency of the Applicant Company's domiciliary state.

Include one copy of the Applicant Company's annual statement for the two (2) preceding years in addition to the most recent annual statement.

Property/Casualty insurers must attach the Insurance Expense Exhibit, Accident and Health Policy Experience Exhibit and/or Schedule P to the annual statement.

Life insurers must include a Certificate of Valuation from the domiciliary state insurance regulatory agency.

Members of a holding company system must attach a copy of the most recent consolidated annual statement, if filed with its current state of domicile. Submit the annual statement, with the necessary attachments, as Item 15 of the application.

16. Quarterly Statements

Include one (1) copy of each quarterly statement that follows the most recent annual statement. In addition, the Applicant Company must immediately forward any new quarterly statements that become available while the application is pending to all states in which applications are pending. Submit the quarterly statements as Item 16 of the application.

17. Risk-Based Capital Report

Include a Risk-Based Capital Report, submitted in the level of detail required by the NAIC, as Item 17 of the application. Please note that the states will maintain confidentiality of these reports.

18. Independent CPA Audit Report

Include a CPA Audit Report, performed by a certified public accountant that is not an employee of the Applicant Company. Submit the CPA Audit Report as Item 18 of the application. Some states allow exemptions to this requirement for small insurers. Please contact the states individually regarding exemptions.

19. Reports of Examination

The application must include a copy of the Applicant Company's most recent Report of Financial Examination from its domiciliary state. The Applicant Company must also note all more recent examinations completed by any state, including market conduct examinations, and provide a description of each examination. The Reports of Examination Requirements chart is

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available on the UCAA website. Submit the Report of Financial Examination and a list of more recent examinations with descriptions as Item 19 of the application.

20. Certificate of Compliance

Include a Certificate of Compliance (Form 6) with the application. Please refer to the Certificate of Compliance and Certificate of Deposit Requirements chart on the UCAA website for specific requirements for the date of issuance of the Certificate of Compliance (Form 6) from the file date of the application. The current domiciliary state must complete the Certificate of Compliance. Submit as Item 20 of the application.

Primary Application Section IV
How to File

To facilitate the prompt review of the Primary Application, please ensure that the application adheres to the formatting instructions provided in this section. States will not accept for filing any applications that fail to meet these formatting requirements. Section IV will address the following areas:

1. Communication Between Applicant Company and Agency
2. Questions
3. Application Checklist
4. Application and Supporting Documents
5. Addresses for Submission of Application
6. Updates/Changes
7. Filing Fee
8. Forms
9. State-Specific Information

1. Communication Between Applicant Company and Agency

Once the state accepts a Primary Application for filing, the state will notify the Applicant Company of the official filing date and agency contact person. The state will provide names, addresses, email (if available) and telephone numbers of the individual(s) assigned to the application.

Prior to receiving the name of the agency contact person, an Applicant Company may contact the agency personnel listed on the Addresses and Contacts for Submission of Application chart located on the UCAA website to obtain information regarding the status of a Primary Application.

2. Questions

Section II and Section III, Filing Requirements, provide detailed guidelines regarding both the type and format of information required for the Primary Application. In most cases, the state provides an agency contact person for each item in the Filing Requirements section. For additional information, or clarification, Applicant Company's may use the contact names provided in the Addresses and Contacts for Submission of Application chart located on the UCAA website.

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3. Application Checklist

The application checklist (Form 1P) is available on the UCAA website and provides a guide for assembling a complete application. Complete the checklist before submitting a Primary Application for review. Attach a completed checklist to the top of each application.

4. Application and Supporting Documents

Submit one copy of the Checklist, completed application and all supporting documentation to the reviewing state. California, Kentucky and New York require two (2) complete copies. Each item identified in Section II and Section III of the Filing Requirements should have a cover sheet as specified below.

Each cover sheet should be on paper suitable for use as a cover sheet, such as binder divider pages.

The Applicant Company needs to tab each cover sheet on the right-hand side of the page with a number corresponding to the document's item number in the Primary Application checklist.

If a particular item is not included with the cover sheet, the Applicant Company must attach to the cover sheet a written explanation stating the reason the item has not been included. Set forth below are examples of why the Applicant Company may not attach a particular item to the cover sheet.

- "Item not applicable to this application for the following reason ... (state reason)."
- "Item has been attached separately because of size."

5. Addresses for Submission of Application

Submit the application by mailing it to the appropriate address noted on the chart, Addresses and Contact Information for Submission of Application, on the UCAA website.

6. Updates/Changes

The Applicant Company is responsible for informing states of any significant changes that occur or that the Applicant Company discovers during the application review period. Examples of significant changes include: changes in officers and directors, material acquisition or disposal of assets, changes in reinsurance, acquisition of the insurer, change in proposed shareholders, regulatory actions taken against the insurer, change in current business plan, etc.

The Applicant Company must supply revised forms promptly if any changes occur that materially affect the accuracy of the forms filed in support of the application. For example, the Applicant Company must forward new quarterly statements as soon as they become available.

7. Filing Fee

Please see the Filing Fees - Primary and Expansion Applications located on the UCAA website to determine the correct fee and filing instructions for the application state.

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8. Forms

All forms are available on the UCAA website under the Primary Application tab and UCAA Forms. All forms can be downloaded, printed and submitted with a completed application. The forms MUST NOT be altered. At this time, the forms cannot be submitted electronically.

9. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before a state can issue a Certificate of Authority. Before completing a UCAA Primary Application, the Applicant Company should review a listing of requirements for the application state. State requirements are on the UCAA website under State-Specific Requirements.

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UNIFORM CERTIFICATE OF AUTHORITY APPLICATION

EXPANSION APPLICATION

The Expansion Application to the Uniform Certificate of Authority Application (UCAA) is for use by an Applicant Company that wishes to expand into one or more Uniform States. The Applicant Company may file Expansion Applications simultaneously in as many states as desired. Prior to submitting an application in a foreign state, the Applicant Company should inform the state of domicile of its plans in the foreign state(s).

The Expansion Application is an abbreviated version of the UCAA designed to allow solidly performing companies that are in good standing in all admitted states to gain admission into new states quickly and easily. It is the goal of all Uniform States to complete their review of Expansion Applications within 60 calendar days of receipt. The 60-day review process includes two weeks to determine if the application is complete and acceptable. During the remaining 45–60 day time span, the application will receive a financial and operational review. The states may not achieve the 60-day processing goal in instances where substantial follow-up is required or in states with limited resources or in instances when the Applicant Company files an application during peak business periods, such as year-end and annual statement filing periods.

Based on the circumstances of a particular application, it may be necessary for the reviewing state to request additional information.

The UCAA Expansion Application has three sections designed to guide the Applicant Company through the admission process:

I. Application Review Process
II. Filing Requirements
III. How to File

The goal of the UCAA is to provide a streamlined approval process. However, some states have state-specific filing requirements based on either statutory requirements or internal procedures. All Applicant Companies must be familiar with the insurance laws of the state to which they submit an application. Please see the UCAA website for information on obtaining a copy of the laws, regulations and bulletins for each state.

Direct any questions about the uniform admission process or state-specific filing requirements to the contact shown on the list of contact names and telephone numbers provided on the UCAA website. To assure a prompt review, the Applicant Company should contact each state with any questions before submitting the application.

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Expansion Application Section I
Application Review Process

The Expansion Application is an abbreviated version of the UCAA designed to allow solidly performing companies that are in good standing in all admitted states to gain admission into new states quickly and easily. It is the goal of all Uniform States to complete their review of Expansion Applications within 60 calendar days of receipt. The 60-day review process includes two weeks to determine if the application is complete and acceptable. During the remaining time span, the application will receive a financial and operational review. The states may not achieve the 60-day processing goal in instances where substantial follow-up is required or in states with limited resources or in instances when the Applicant Company files an application during peak business periods, such as year-end and annual statement filing periods.

Based on the circumstances of a particular application, it may be necessary for the reviewing state to request additional information.

Proprietary Information

Both regulators and the Applicant Company should note that communications with insurance regulatory agencies in conjunction with the Expansion Application concerning proprietary information about the Applicant Company may be deemed confidential. States may only share information determined to be confidential with other persons as authorized by law. By law, the state will not disclose to the public any information determined to be proprietary and trade secret. Each Applicant Company needs to expressly identify all information in the application and in any subsequent correspondence that the Applicant Company considers proprietary or trade secret.

Please do not hesitate to contact the appropriate state insurance regulators with any questions before filing any Uniform Application.

Step One: Filing the Application
Processing Goal: 2 Weeks

The Applicant Company may submit an Expansion Application anytime during the year. States will immediately review the Expansion Application to ensure that the Applicant Company submits the application in the required format as outlined in these instructions.

Generally, within two weeks from the date the state receives the application, the state will notify the Applicant Company whether or not the state has accepted the application for filing. If the state accepts the application for filing, the state will assign an official filing date.

The state will contact the Applicant Company if it does not accept the application for filing due to a deficiency in the application's format. Depending upon the nature of the deficiency, the state may give the Applicant Company two weeks from the date of receipt of notification to correct the deficiency. Some states may return to the Applicant Company applications that are deficient and not accepted for filing.

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Step Two: Application Review
Processing Goal: 45–60 Days

An Expansion Application will undergo a rigorous financial and operational review in each state to which the Applicant Company submits the application. While the goal of each state is to complete this review in 60 days, the states cannot guarantee this time frame. Due to the varying levels of resources available in each state, a substantive review of an Expansion Application may take longer than 60 days in some cases. Furthermore, if the state needs additional information to complete a substantive review of an application, the review may also take longer to complete. Once the state requests additional information, it suspends the 60-day goal until it receives the requested information. The purpose of the Expansion Application is to streamline application processing and the states will make every effort to process an Expansion Application as quickly as possible.

At the conclusion of each state's substantive review, the state will grant the Applicant Company a Certificate of Authority, it will allow the Applicant Company to withdraw the application or it will deny the application. Each state independently reaches a decision to either approve or deny an Expansion Application. It is entirely possible that some states might approve an Expansion Application and other states might deny the application.

If any state denies the application, that state will notify the Applicant Company and provide a detailed explanation for the denial. After the denial, if the Applicant Company wishes to re-file an Expansion Application, the state will require a new application and filing fee.

Since only established companies can use an Expansion Application, the states assume that the Applicant Company has a basic understanding of the Certificate of Authority review process. Please refer to the Primary Application for a more detailed explanation of the process. The Applicant Company is strongly encouraged to contact the states with questions before submitting an application for review.

Expansion Application Section II
Filing Requirements

This section provides a guide to understanding the focus of each document of the Expansion Application. However, there typically are multiple purposes for the documents. Therefore, it is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents, although generally no more than five (5) years old. Please contact the states individually if there are questions about a specific document.

All forms required for the Expansion Application are located under the Expansion Application tab in the UCAA Forms Section on the UCAA website.

Table of Contents

1. Expansion Application Form
2. Filing Fee
3. Minimum Capital and Surplus Requirements

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4. Statutory Deposit Requirements
5. Name Approval
6. Plan of Operation
7. Holding Company Act Filings
8. Certificate of Compliance
9. Reports of Examination
10. Statutory Memberships
11. Public Records Package
12. NAIC Biographical Affidavits
13. Uniform Consent to Service of Process
14. State-Specific Information

1. Application Form and Attachments

The application must identify all lines of insurance the Applicant Company is currently licensed to transact in its state of domicile and all lines of insurance the Applicant Company is requesting authority to transact, as identified by the Applicant Company's plan of operation. Submit a completed checklist (Form 1E) and original executed application form (Form 2E and Form 3) as Item 1 of the application. A cover letter may be included as a component of Item 1 of the application.

2. Filing Fee

Include a filing fee for each application state. Please issue a separate check for each state. The payee name and the instructions for submitting the filing fee are included in the Filing Fees - Primary and Expansion Applications chart on the UCAA website. Please note that due to retaliatory statutes, the ultimate amount of fees in any state may be more than the amount indicated in the chart. Submit a copy of the Applicant Company's check as Item 2 of the application.

3. Minimum Capital and Surplus Requirements

The application must show that the Applicant Company meets each state's statutory minimum capital and surplus requirements. In some states, the minimum capital and surplus requirements are determined by the classes of insurance that the Applicant Company is requesting authority to transact and the classes of insurance the Applicant Company is authorized to transact in all other jurisdictions. The state will determine the level of surplus required after considering the Applicant Company's product line, operating record and financial condition. Compliance with the statutorily prescribed minimum surplus requirement may not be sufficient for all applicants. The Minimum Capital and Surplus Requirements chart on the UCAA website identifies the minimum capital and surplus requirements for each Uniform State. The chart also provides a contact person or a link to a state-specific format or RBC requirements and instructions. Submit an explanation of the Applicant Company's compliance with the capital and surplus requirements as Item 3 of the application.

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4. Statutory Deposit Requirements

Some states require that a statutory deposit be on file in the domiciliary state. The Statutory Deposit Requirements chart on the UCAA website provides specific requirements and identifies those states that require deposits by foreign insurers and proof of a Statutory Deposit in the domiciliary state. A foreign insurer is an insurer that is domiciled in another state. Please refer to the Certificate of Compliance and Certificate of Deposit Requirements chart on the UCAA website for specific requirements for the date of issuance of the Certificate of Deposit (Form 7) from the file date of the application. Unless otherwise indicated, the statutory deposit is for the benefit of all policyholders. In the states where proof is required, the Applicant Company should submit the Certificate of Deposit (Form 7) prepared by its state of domicile as Item 4 of the application.

5. Name Approval

Each state has different guidelines and procedures for name approval. The Name Approval Requirements chart on the UCAA website serves as a guide for the various name approval requirements of each Uniform State. The Applicant Company should check with each state separately to ensure compliance with all applicable name approval requirements. Where applicable, submit evidence of name approval request as Item 5 of the application.

6. Plan of Operation

The plan of operation has three components, a brief narrative, proforma financial statements/projections and a completed Questionnaire (Form 8). The narrative should include significant information not captured as a part of the Questionnaire that the company submits in support of the application. The proforma is one of the three (3) components in the Plan of Operation. The forms are located on the UCAA website under the Expansion Application tab. There is a proforma for Life, Property/Casualty, Health and Title companies. Provide a company-wide, three-year proforma balance sheet and income statement. The proforma workbook should be the same business type as the financial statement blank filed with the NAIC. For the lines requested, provide three-year premium and loss projections by line for the application state. Projections must support all aspects of the proposed plan of operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections.

The proforma when applied to the expansion application is projected data. As such, the projected amounts need not balance with historical NAIC financial filings. The projected data, however, should be relevant to the Applicant Company's history of growth and losses as contemplated by the NAIC *Accounting Practices and Procedures Manual.*

The proforma should be completed by statutory accounting or financial reporting professionals that should be available to answer any questions or concerns from reviewing regulatory staff. The proforma is completed on an annual basis, typically for a three-year time period, however, some states may require five years. The proforma should start with the first full year of operation that the Applicant Company anticipates actively writing business in the state(s) receiving the application.

Submit the completed Questionnaire and all attachments as Item 6 of the application.

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7. Holding Company Act Filings

If the Applicant Company is a member of a holding company system, the application must include either the most recent Holding Company Act (HCA) filings, including the Annual Form "B" Registration Statement and related Form F, or a statement substantially similar to the NAIC *Insurance Holding Company System Regulatory Act* (#440). The filing should include all attachments, exhibits and appendices referenced in the HCA filings. Submit the HCA filings as Item 7 of the application and include all attachments and any amendments up to the filing date of the application.

8. Certificate of Compliance

The application must include a Certificate of Compliance. Please refer to the Certificate of Compliance and Certificate of Deposit Requirements chart on the UCAA website for specific requirements for the date of issuance of the Certificate of Compliance (Form 6) from the file date of the application. The domiciliary state must complete the Certificate of Compliance (Form 6) and the Applicant Company must submit this as Item 8 of the application.

9. Reports of Examination

The application must include a copy of the Applicant Company's most recent Report of Financial Examination from its domiciliary state. The Applicant Company must also note all more recent examinations completed by any state, including market conduct examinations, and include a description of each examination. The Reports of Examination Requirements chart is available on the UCAA website. Submit the Report of Financial Examination and a list of more recent examinations with descriptions as Item 9 of the application.

10. Statutory Memberships

In some states, the Applicant Company is required to join one or more rating, guaranty or other organizations before transacting insurance. Generally, the authorized lines of insurance the Applicant Company can transact govern statutorily mandated memberships. Please be sure to check with each application state to inquire about any statutory memberships required before transacting insurance. The Statutory Membership Requirements chart is on the UCAA website. Submit documentation supporting membership application(s) in states where required, as Item 10 of the application.

11. Public Records Package

Most states have requirements to disclose information to the public under a Public Records Act. To meet these public disclosure requirements certain items must accompany the application. While these documents may or may not be part of the substantive review, please be sure to include the documents with the application. The Public Records Package chart may be accessed on the UCAA website. Submit all documents listed for the application state as Item 11 of the application.

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12. NAIC Biographical Affidavits

A. The Applicant Company is required to submit an NAIC Biographical Affidavit (Form 11) in connection with pending or future application(s) for licensure or a permit to organize with a department of insurance in one or more states. The Applicant Company must submit an NAIC Biographical Affidavit on behalf of all officers, directors and key managerial personnel of the Applicant Company and individuals with a ten percent (10%), or more, beneficial ownership in the Applicant Company and the Applicant Company's ultimate controlling parent (Affiant).

B. The UCAA defines "Independent Third-Party" as:

(i) A consumer reporting agency ("CRA") overseen by the Federal Trade Commission ("FTC") and, therefore, subject to the FCRA, which have been vetted and is currently on the approved list;

(ii) Has the ability to perform international background investigations; and

(iii) One whose officers and directors have no material affiliation with the Applicant Company other than stock ownership amounting to less than one percent (1%) of total stock outstanding, unless prior approval is given by the department of insurance to which application is being made.

C. The NAIC Biographical Affidavit requests information with respect to your employment history, education, personal information and character. The NAIC Biographical Affidavit also includes the Disclosure and Authorization Concerning Background Reports Form (the "Disclosure & Authorization Form"). The signature of the Affiant on the Disclosure & Authorization Form permits an Independent Third-Party to conduct an independent third-party verification on the Affiant.

D. The NAIC Biographical Affidavit includes three types of the Disclosure & Authorization Form. There are three different Disclosure & Authorization Forms since certain state laws, regulations and rules require different kinds of disclosures and wording within such form. An Affiant must sign the corresponding Disclosure & Authorization Form(s) for the respective state(s) where the Affiant has lived or worked within the last ten (10) years. Refer to the Disclosure & Authorization Forms for further information.

E. The NAIC Biographical Affidavit is used to evaluate the suitability, competency, character and integrity of the Affiant in connection with an Applicant Company's pending or future application(s) for licensure or a permit to organize with a department of insurance in one or more states.

The Independent Third-Party uses information contained in the NAIC Biographical Affidavit as a tool to perform an independent third-party verification to determine an individual's fitness and propriety. The independent third-party verification may contain information bearing on the Affiant's character, general reputation, personal characteristics, mode of living and credit standing (if required by the state). The Independent Third-Party Vendors shall use the independent third-party verification to create a background report (the "Background Report").

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F. The Disclosure & Authorization Form is valid for a maximum of one year. Additionally, an Affiant may revoke the authorization at any time by delivering a written revocation to the Applicant Company. Refer to the Disclosure & Authorization Form for further information.

G. The Background Reports are subject to the Fair Credit Reporting Act ("FCRA"). Pursuant to FCRA, the state departments of insurance and an Applicant Company who is seeking admission are "users" of consumer reports. The FCRA requires that the Applicant Company provide the Affiant with a copy of the "Summary of Your Rights Under the Fair Credit Reporting Act." Applicant Company's should provide a copy of the "Summary of Your Rights under the Fair Credit Reporting Act" to each Affiant. This summary can be found at the Federal Trade Commission ("FTC") website.

H. The Applicant Company and state departments of insurance are required to comply with FCRA, especially as it relates to confidentiality of the information contained in such consumer reports. To the extent required by law, the states and Third-Party Vendors should maintain the Background Reports procured under the Disclosure & Authorization Form as confidential. A copy of the FCRA is located at here.

I. The department of insurance in the state where an Applicant Company files, or intends to file an application and the Applicant Company may require the Background Report. An Affiant who desires a copy of their Background Report, may request a copy from the Applicant Company or the CRA as indicated on the Disclosure & Authorization Form. Refer to the Disclosure & Authorization Form for further information.

J. Please **check state requirements** for those states that require additional background information, such as fingerprints, in place of, or in addition to, NAIC Biographical Affidavits. If applying in one of those states, necessary fingerprints and processing fees should be included.

Refer to the UCAA website for a **list of currently approved Independent Third-Party Vendors for Background Reports**.

NAIC Biographical Affidavits must be completed on the most **current form [Word | PDF]**, in effect at the time the affidavit was signed and the affiant shall not sign the Affidavits more than one year before the date the Applicant Company files the application.

Submit original Biographical Affidavits (Form 11) that contain the Disclosure & Authorization Forms to the state department(s) of insurance as Item 12 of the application.

13. Uniform Consent to Service of Process

Many jurisdictions require that the Applicant Company designate the insurance commissioner or a resident agent to receive service of process on behalf of the Applicant Company. In addition, the Applicant Company must designate a person or entity to receive a forwarded service of process after the commissioner receives the served documents. The Uniform Consent to Service of Process and the Resolution Authorizing Appointment of Attorney (Form 12) are required for this purpose. However, four states do not accept the Uniform Consent to Service of Process form. Those states are: California, Massachusetts, Virginia and Wisconsin. For those states,

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please see the State-specific Requirements on the UCAA website for any information regarding this subject. Pennsylvania does not accept service of process and does not require a form. Submit the Uniform Consent to Service of Process and Resolution Authorizing Appointment of Attorney as Item 13 of the application.

14. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet other than that required above. Before completing a UCAA Expansion Application, the Applicant Company should review a listing of requirements for the state to which an application is being submitted. State-specific information is available on the UCAA website. Submit state-specific items as Item 14 of the application.

Expansion Application Section III

How to File

To facilitate the prompt review of the Expansion Application, please ensure that the application adheres to the formatting instructions provided in this section. The state will not accept for filing any applications that fail to meet these formatting requirements.

Table of Contents

1. Communication Between Applicant Company and Agency
2. Questions
3. Application Checklist
4. Application and Supporting Documents
5. Addresses for Submission of Application
6. Updates/Changes
7. Filing Fee
8. Forms
9. State-Specific Information

1. Communication Between Applicant Company and Agency

Once a state has accepted an Expansion Application for filing, the state will notify the Applicant Company of the filing date and provide the agency contact person. The state will provide the names, addresses, email (if available) and telephone numbers of the individual(s) assigned to the application.

Before receiving the name of the agency contact person, the Applicant Comapny may contact the agency personnel in the Addresses and Contact Information for Submission of Application chart on the UCAA website to obtain information regarding the status of an Expansion Application.

2. Questions

Section II, Filing Requirements, provides detailed guidelines regarding both the type and format of information required for the Expansion Application. In most cases, the state provides an agency contact person for each item in the Filing Requirements section. For additional

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information, or clarification, the Applicant Company may use the contact names provided on the Addresses and Contact Information for Submission of Application chart on the UCAA website.

3. Application Checklist

The Application Checklist (Form 1E) in the Forms Section provides a guide for assembling a complete application. Complete the checklist before submitting an Expansion Application for review. Attach a completed Checklist to the top of each application.

4. Application and Supporting Documents

Submit one copy of the Checklist, completed application and all supporting documentation to each reviewing state. California, Kentucky and New York require two (2) complete copies. Each item identified in Section II Filing Requirements should have a cover sheet as specified below.

Each cover sheet should be on paper suitable for use as a cover sheet, such as binder divider pages.

Tab each cover sheet on the right-hand side of the page with a number corresponding to the document's item number in the "Filing Requirements" section of the Expansion Application.

If a particular item is not included with the cover sheet, attach a written explanation to the cover sheet stating the reason the item has not been included. These are examples of why the Applicant Company may not attach a particular item to the cover sheet:

- "Item not applicable to this application for the following reason ... (state reason)."
- "Item has been attached separately because of size."

5. Addresses for Submission of Application

Submit the application by mailing it to the appropriate address noted on the chart, Addresses and Contact Information for Submission of Application, on the UCAA website.

6. Updates/Changes

The Applicant Company is responsible for informing states of any significant changes that occur or that the Applicant Company discovers during the application review period. Examples of significant changes include: changes in officers and directors, material acquisition or disposal of assets, changes in reinsurance, acquisition of the insurer, redomestication of the insurer, regulatory actions taken against the insurer, change in current business plan, etc.

The Applicant Company must supply revised forms promptly if any changes occur that materially affect the accuracy of the forms filed in support of the application. For example, the Applicant Company must forward new quarterly statements as soon as they become available.

In addition, all carriers admitted to transact insurance in any Uniform State are required to maintain their Certificate(s) of Authority in good order to ensure ongoing compliance with all applicable laws, regulations and bulletins.

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7. Filing Fee

A schedule of filing fees is available on the UCAA website to determine the correct fee and filing instructions for the state to which the Applicant Company is applying.

8. Forms

All forms are available on the UCAA website.

9. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can issue a Certificate of Authority. Before completing a UCAA Expansion Application, the Applicant Company should review a list of requirements for the state to which the Applicant Company is applying. These requirements are located under State-Specific Requirements on the UCAA website.

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UNIFORM CERTIFICATE OF AUTHORITY APPLICATION

CORPORATE AMENDMENTS APPLICATION

An existing insurer uses the Uniform Certificate of Authority Corporate Amendments Application for requesting amendments to its Certificate of Authority. A Uniform State is one that is committed to using the Uniform Certificate of Authority (UCAA) review process for company licensing and admissions.

The Applicant Company can use the Corporate Amendments Application to file more than one change in the same submission. The Applicant Company should mark all changes it files on the application form and submit all items required for those changes.

The following pages contain a detailed explanation of the various requirements, along with instructions designed to assist in the preparation and submission of the necessary documentation to obtain regulatory approval. Each state's review process may follow slightly different time lines to complete a comprehensive and detailed operational and financial review of the Applicant Company's business. It is the goal of all Uniform States to complete their review of the Corporate Amendments Applications within 60 calendar days of receipt. The 60-day review process includes two weeks to determine if the application is complete and acceptable for filing. During the remaining time-span, the application will receive a financial and operational review. The state may not achieve the 60-day processing goal in instances where the application requires substantial follow-up, or in states with limited resources, or in instances when the Applicant Company files an application during peak business periods such as year-end and annual statement filing periods.

Based on the circumstances of a particular application, it may be necessary for the reviewing state to request additional information. Typically, the state will request any additional information within 30 days after it accepts the application.

The UCAA Corporate Amendments Application has twelve sections designed to guide the applicant through the licensing process;

I. Application Review Process
II. Adding and Deleting Lines of Business Filing Requirements
III. Name Change Filing Requirements
IV. Redomestication of a Foreign Insurer Filing Requirements
V. Change of Statutory Home Office Address Filing Requirements
VI. Change of Address/Contact Notification Filing Requirement
VII. Merger of Two or More Foreign Insurers
VIII. Proposed/Completed Change of Control of Foreign Insurers
IX. Amended Articles of Incorporation
X. Amended Bylaws
XI. Statement of Withdrawal/Complete Surrender of Certificate of Authority Application
XII. Uniform Consent to Service of Process
XIII. How to File

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The goal of the UCAA is to provide a streamlined approval process. However, some states have state-specific filing requirements based on either statutory requirements or internal procedures. The Applicant Company must be familiar with the insurance laws of the state to which they submit an application. Please see State Charts on the UCAA website for information about how to obtain a copy of the laws, regulations and bulletins for the application state.

If there are any questions about the uniform amendment process, a list of contact names, addresses and telephone numbers is available on the UCAA website. It is highly recommended that the Applicant Company contact each state with any questions before submitting the application for review.

Corporate Amendments Application Section I
Application Review Process

The Corporate Amendments Application of the UCAA provides a uniform process for gaining the necessary regulatory approvals for modifications to an Applicant Company's Certificate of Authority. It is the goal of each Uniform State to process all Corporate Amendments Applications within 60 calendar days of receipt. The 60-day review process includes two weeks to determine if the application is complete and acceptable for filing. During the remaining time-span, the application will receive a financial and operational review. The states may not achieve the 60-day processing goal in instances where the application requires substantial follow-up, or in states with limited resources or in instances when the Applicant Company files an application during peak business periods such as year-end and annual statement filing periods.

Based on the circumstances of a particular application, it may be necessary for the reviewing state to request additional information. Typically, the state will request any additional information that it needs within 30 days after the state accepts the application.

Proprietary Information

Both regulators and the Applicant Company should note that the Applicant Company might deem confidential any communications with insurance regulatory agencies in conjunction with the Corporate Amendments Application concerning proprietary information about the Applicant Company. States may only share information determined to be confidential with other persons as authorized by law. By law, the state will not disclose to the public any information determined to be proprietary and trade secret. Each Applicant Company needs to expressly identify all information in the application and in any subsequent correspondence that the Applicant Company considers proprietary or trade secret.

The UCAA website explains the requirements and filing process for the Corporate Amendments Application. Please do not hesitate to contact the appropriate state regulators with any questions before filing any Uniform Application.

Step One: Filing the Application
Processing Goal: 2 Weeks

An Applicant Company may submit Corporate Amendments Applications anytime during the year. The state immediately reviews Corporate Amendments Applications to ensure that the Applicant Company submits these in the required format as outlined in Section II through Section XI.

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Generally, within two weeks from the date the state receives the application, the state notifies the Applicant Company whether or not it has accepted the application for filing. If the state accepts the application for filing, it will assign an official filing date.

The state will contact the Applicant Company if it does not accept the application for filing due to a deficiency in the application's format. Depending upon the nature of the deficiency, the state may give the Applicant Company two weeks from the date of receipt of notification from the department reviewing the application to correct the deficiency. Some states may return to the Applicant Company any applications that are deficient and not accepted for filing.

Step Two: Application Review
Processing Goal: 60 Days

A Corporate Amendments Application will undergo a rigorous financial and operational review in the application state. While the goal of each state is to complete this review in 60 days, the state cannot guarantee this time frame. Due to varying levels of resources available in each state, a substantive review of the Corporate Amendments Application may take longer than 60 days in some cases. Furthermore, if the state needs additional information to complete a substantive review of an application, the review may also take longer to complete. Once the state makes a request for additional information, it suspends the 60-day goal until the state receives the requested information. The purpose of the Corporate Amendments Application is to streamline application processing and the states will make every effort to process a Corporate Amendments Application as quickly as possible.

At the conclusion of the substantive review by the reviewing state, the state will grant the Applicant Company an amendment to the Certificate of Authority, allow the Applicant Company to withdraw the application, or will deny the application.

If the state denies the application, the state will notify the Applicant Company and provide a detailed explanation for the denial. After the denial, if the Applicant Company wishes to re-file a Corporate Amendments Application, the state will require a new application and filing fee.

Corporate Amendments Application Section II
Filing Requirements (Adding and Deleting Lines of Business)

This section provides a guide to understanding the focus of each document of the Corporate Amendments Application. However, there typically are multiple purposes for documents. Therefore, it is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents. Please contact the states individually if there are questions about a specific document.

All forms required for the Corporate Amendments Application are located under the Corporate Amendment Application tab in the UCAA Forms Section on the UCAA website.

Table of Contents

1. Application Form and Attachments
2. Filing Fee
3. Articles of Incorporation
4. Bylaws
5. Minimum Capital and Surplus Requirements
6. Statutory Deposit Requirements
7. Plan of Operation
8. Statutory Membership(s)
9. Certificate of Compliance
10. State-Specific Information
11. Deleting Lines of Business

1. Application Form and Attachments

The application must identify all lines of insurance that the Applicant Company is requesting authority to add or delete from an existing Certificate of Authority, as identified by the Applicant Company's plan of operation. Submit a completed Checklist (Form 1C), and an original executed Application Form (Form 2C), completed Lines of Business (Form 3) and the Applicant Company's original Certificate of Authority or an affidavit of lost Certificate of Authority (Form 15) as Item 1 of the application. All Forms for the Corporate Amendments Application are located under the Corporate Amendment Application tab on the UCAA website. A cover letter may be included as a component of Item 1 of the application.

2. Filing Fee

The application must include a filing fee for the application state. The payee name and the instructions for submitting the filing fee are included in the Filing Fees - Corporate Amendments chart located on the UCAA website. Submit a copy of the Applicant Company's check as Item 2 of the application.

3. Articles of Incorporation

Indicate the location of the language within the Articles of Incorporation that allows the Applicant Company to write this line (e.g., page number, section number, etc., of the Articles of Incorporation). In addition:

- If the Articles of Incorporation have changed because of this application, file the amended Articles of Incorporation.
- If the Articles of Incorporation most recently filed in the application state have not changed because of this application, do not file the Articles of Incorporation. Simply state that the current Articles of Incorporation are already on file in the application state.

Include as Item 3 of the application.

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4. Bylaws

The Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed because of this application, file the amended bylaws.
- If the bylaws most recently filed in the application state have not changed because of this application, do not file the bylaws. Simply state that the current bylaws are already on file in the application state.

Include as Item 4 of the application.

5. Minimum Capital and Surplus Requirements

The application will need to show that the Applicant Company meets the state's statutory minimum capital and surplus requirements for the requested amendment to its Certificate of Authority. In some states, the minimum capital and surplus requirements are determined by the classes of insurance that the Applicant Company is requesting authority to transact and the classes of insurance the Applicant Company is authorized to transact in all other jurisdictions. The state will determine the level of surplus required after considering the Applicant Company's product line, operating record and financial condition. Compliance with the statutorily prescribed minimum surplus requirement may not be sufficient for all Applicant Companies. The Minimum Capital and Surplus Requirements chart located on the UCAA website identifies the minimum capital and surplus requirements for each Uniform State. This chart also provides a contact person or a link to a state-specific format or RBC requirements and instructions. Submit an explanation of the Applicant Company's compliance with the capital and surplus requirements as Item 5 of the application.

6. Statutory Deposit Requirements

A Statutory Deposit may be required for the requested modification. The Statutory Deposit Requirements chart located on the UCAA website provides state-specific requirements and identifies those states that require a Statutory Deposit. Unless otherwise indicated the Statutory Deposit is for the benefit of all policyholders. Please refer to the Certificate of Compliance and Certificate of Deposit Requirements chart on the UCAA website for specific requirements for the date of issuance of the Certificate of Deposit (Form 7) from the date of the application. The Applicant Company should submit as Item 6 the Certificate of Deposit (Form 7) prepared by the state of domicile.

7. Plan of Operation

The Plan of Operation has three components, a brief narrative, proforma financial statements/projections and a completed Questionnaire (Form 8C). The narrative should include significant information not captured as a part of the Questionnaire that the Applicant Company submits in support of the application. The proforma is one of three (3) components in the Plan of Operation. The forms are located on the UCAA website under the Corporate Amendment tab. There is a proforma for Life, Property/Casualty, Health and Title companies. Provide a company-wide, three-year proforma balance sheet and income statement. The proforma workbook should be the same business type as the financial statement blank filed with the NAIC. For the lines requested, provide three-year premium and loss projections by line for the

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application state. Projections must support all aspects of the proposed Plan of Operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections.

The proforma when applied to the corporate amendment application is projected data. As such, the projected amounts need not balance with historical NAIC financial filings. The projected data, however, should be relevant to the Company's history of growth and losses as contemplated by the NAIC *Accounting Practices and Procedures Manual*.

The proforma should be completed by statutory accounting and financial reporting professionals that should be available to answer any questions or concerns from reviewing regulatory staff. The proforma is completed on an annual basis, typically for a three-year time period, however, some state may require five years. The proforma should start with the first full year of operation that the Applicant Company anticipates actively writing business in the state(s) receiving the application.

Submit the completed Questionnaire and all attachments as Item 7 of the application.

8. Statutory Memberships

In some states, the Applicant Company is required to join one or more rating, guarantee or other organizations before transacting insurance. Generally, the Applicant Company's authorized lines of insurance govern statutorily mandated memberships. The Statutory Membership Requirements chart is located on the UCAA website. Please be sure to check with the application state to inquire about any statutory memberships that may be required before transacting insurance. Submit documentation supporting membership application(s), in states where required, as Item 8 of the application.

9. Certificate of Compliance

Include a Certificate of Compliance with the application. Please refer to the Certificate of Compliance and Certificate of Deposit Requirements chart on the UCAA website for specific requirements for the date of issuance of the Certificate of Compliance (Form 6) from the file date of the application. The current domiciliary state must complete the Certificate. Submit as Item 9 of the application.

10. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can amend a Certificate of Authority. Before completing a UCAA Corporate Amendments Application, the Applicant Company should review a listing of requirements for the state to which the Applicant Company is applying. State-specific requirements are located on the UCAA website. Include as Item 10 of the application.

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11. Deleting Lines of Business

Complete Section II of Form 8C (questions 22–25) documenting the following:

a. Utilizing the information contained in Form 3, list all of the lines of business that the Applicant Company is requesting to delete from its Certificate of Authority.
b. Provide a detailed explanation for the Applicant Company's request to delete these lines of business.
c. For each state, indicate the number of policyholders by line of business that will be non-renewed or cancelled if the state approves the Applicant Company's request to delete lines of business.

The UCCA website contains a Deleting Lines of Business Requirements chart of individual state requirements. Provide documentation that complies with all requirements for removal of lines of business from the Certificate of Authority listed as Item 11 of the application.

Corporate Amendments Application Section III
Filing Requirements (Name Change)

This section provides a guide to understanding the focus of each document of the Corporate Amendments Application. However, documents typically serve multiple purposes. Therefore, it is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents. Please contact the states individually if there are questions about a specific document.

All forms required for the Corporate Amendments Application are located under the Corporate Amendment Application tab in the UCAA Forms Section on the UCAA website.

Table of Contents

1. Application Form and Attachments
2. Filing Fee
3. Articles of Incorporation
4. Bylaws
5. Service of Process
6. State of Domicile Approval
7. State-Specific Information
8. Name Approval

1. Application Form and Attachments

The Applicant Company must submit a completed Checklist (Form 1C), an original executed Application Form (Form 2C) and the Applicant Company's original Certificate of Authority or an Affidavit of Lost Certificate of Authority (Form 15) as Item 1 of the application. All forms for the Corporate Amendments Application are located on the UCAA website. A cover letter may be included as a component of Item 1 of the application.

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2. Filing Fee

Include a filing fee for each application state. The payee name and the instructions for submitting the filing fee are included in the Filing Fees - Corporate Amendments chart located on the UCAA website. Submit a copy of the Applicant Company's check as Item 2 of the application.

3. Articles of Incorporation

Indicate the location of the language within the Articles of Incorporation that reflects the new name (e.g., page number, section number, etc., of the Articles of Incorporation). In addition:

- If the Articles of Incorporation have changed because of this application, file the amended Articles of Incorporation.
- If the Articles of Incorporation most recently filed in the application state have not changed because of this application, do not file the Articles of Incorporation. Simply state that the current Articles of Incorporation are already on file in the application state.

Include as Item 3 of the application.

4. Bylaws

The Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed because of this application, file the amended bylaws.
- If the bylaws most recently filed in the application state have not changed because of this application, do not file the bylaws. Simply state that the current bylaws are already on file in the application state.

Include as Item 4 of the application.

5. Service of Process

Include one original fully executed UCAA Service of Process (Form 12) or see state-specific requirements. This form is located on the UCAA website. Include as Item 5 of the application.

6. State of Domicile Approval (Foreign Insurers Only)

Provide a copy of the name change approval from the Applicant Company's state of domicile. Include as Item 6 of the application.

7. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can amend a Certificate of Authority. Before completing a UCAA Corporate Amendments Application, the Applicant Company should review a listing of requirements for the state to which the Applicant Company is applying. State-specific requirements are located on the UCAA website. Include as Item 7 of the application.

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8. Name Approval

Each state has different guidelines and procedures for name approval. The Name Approval Requirements chart located on the UCAA website is intended to serve as a guide for the various name approval requirements of each Uniform State. The Applicant Company should check with each state separately to ensure compliance with all applicable name approval requirements. Where applicable, submit evidence of name approval request as Item 8 of the application.

The Applicant Company must notify the NAIC once the domiciliary state approves the name change prior to preparation of the electronic application. Email approval to: *fdrccreq@naic.org*.

Corporate Amendments Application Section IV
Filing Requirements (Redomestication of a Foreign Insurer)

This section provides a guide to understanding the focus of each document of the Corporate Amendments Application. However, documents typically serve multiple purposes. Therefore, it is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents. Please contact the states individually if there are questions about a specific document.

All forms required for the Corporate Amendments Application are located under the Corporate Amendment Application tab in the UCAA Forms Section on the UCAA website.

Table of Contents

1. Application Form and Attachments
2. Filing Fee
3. Articles of Incorporation
4. Bylaws
5. Statutory Deposit Requirements
6. Service of Process
7. State of Domicile Approval (Foreign Insurers Only)
8. State-Specific Information

1. Application Form and Attachments

Submit a completed Checklist (Form 1C), and an original executed Application (Form 2C) and the Applicant Company's original Certificate of Authority or an Affidavit of Lost Certificate of Authority (Form 15) as Item 1 of the application. A cover letter may be included as a component of Item 1 of the application.

2. Filing Fee

Include a filing fee for each application state. The payee name and the instructions for submitting the filing fee are included in the Filing Fees - Corporate Amendments chart located on the UCAA website. Submit a copy of the Applicant Company's check as Item 2 of the application.

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3. Articles of Incorporation

Indicate the location of the language within the Articles of Incorporation that reflects the redomestication (e.g., page number, section number, etc., of the Articles of Incorporation). In addition:

- If the Articles of Incorporation have changed because of this application, file the amended Articles of Incorporation.
- If the Articles of Incorporation most recently filed in the application state have not changed because of this application, do not file the Articles of Incorporation. Simply state that the current Articles of Incorporation are already on file in the application state.

Include as Item 3 of the application.

4. Bylaws

The Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed because of this application, file the amended bylaws.
- If the bylaws most recently filed in the application state have not changed because of this application, do not file the bylaws. Simply state that the current bylaws are already on file in the application state.

Include as Item 4 of the application.

5. Statutory Deposit Requirements

A Statutory Deposit may be required for the requested modification. The Statutory Deposit Requirements chart located on the UCAA website provides state-specific requirements and identifies those states that require a Statutory Deposit. Unless otherwise indicated the Statutory Deposit is for the benefit of all policyholders. Please refer to the Certificate of Compliance and Certificate of Deposit Requirements chart on the UCAA website for specific requirements for the date of issuance of the Certificate of Deposit (Form 7) from the files date of the application. The Applicant Company should submit as Item 5 the Certificate of Deposit (Form 7) prepared by its state of domicile.

6. Service of Process

Include one original fully executed UCAA Service of Process form (Form 12) or state-specific requirements. Include as Item 5 of the application.

7. State of Domicile Approval

Provide a copy of the redomestication approval from the Applicant Company's state of domicile. Include as Item 6 of the application.

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The Applicant Company must notify the NAIC once the domiciliary state approves the redomestication prior to preparation of the electronic application. Email approval to: *fdrccreq@naic.org*.

8. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can amend a Certificate of Authority. Before completing a UCAA Corporate Amendments Application, the Applicant Company should review a listing of requirements for the application state. State-specific requirements are located on the UCAA website. Include as Item 7 of the application.

Corporate Amendments Application Section V
Filing Requirements (Change of Statutory Home Office Address)

This section provides a guide to understanding the focus of each document of the Corporate Amendments Application. However, documents typically serve multiple purposes. Therefore, it is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents. Please contact the states individually if there are questions about a specific document.

All forms required for the Corporate Amendments Application are located under the Corporate Amendment Application tab in the UCAA Forms Section on the UCAA website.

Table of Contents

1. Application Form and Attachments
2. Filing Fee
3. Articles of Incorporation
4. Bylaws
5. Service of Process
6. State of Domicile Approval (Foreign Insurers Only)
7. State-Specific Information

1. Application Form and Attachments

The Applicant Company must submit a completed Checklist (Form 1C), and an original executed Application (Form 2C) and the Applicant Company's original Certificate of Authority or an Affidavit of Lost Certificate of Authority (Form 15), if required as Item 1 of the application. A cover letter may be included as a component of Item 1 of the application.

2. Filing Fee

The application will need to include a filing fee for the application state. The payee name and the instructions for submitting the filing fee are included in the Filing Fees - Corporate Amendments chart located on the UCAA website. Submit a copy of the Applicant Company's check as Item 2 of the application.

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3. Articles of Incorporation

Indicate the location of the language within the Articles of Incorporation that reflects the change of statutory home office address (e.g., page number, section number, etc., of the Articles of Incorporation). In addition:

- If the Articles of Incorporation have changed because of this application, file the amended Articles of Incorporation.
- If the Articles of Incorporation most recently filed in the application state have not changed because of this application, do not file the Articles of Incorporation. Simply state that the current Articles of Incorporation are already on file in the application state.

Include as Item 3 of the application.

4. Bylaws

The Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed because of this application, file the amended bylaws.
- If the bylaws most recently filed in the application state have not changed because of this application, do not file the bylaws. Simply state that the current bylaws are already on file in the application state.

Include as Item 4 of the application.

5. Service of Process

Include one original fully executed UCAA Service of Process form (Form 12) or state-specific requirements. Include as Item 5 of the application.

6. State of Domicile Approval (Foreign Insurers Only)

Provide a copy of the approval from the Applicant Company's state of domicile. Include as Item 6 of the application.

7. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can amend a Certificate of Authority. Before completing a UCAA Corporate Amendments Application, the Applicant Company should review a listing of requirements for the application state. State-specific requirements are located on the UCAA website. Attach a completed Form 14, if contact address information has changed because of this application. Include as Item 7 of the application.

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Corporate Amendments Application Section VI
Filing Requirements (Change of Address/Contact Notification – Stand Alone)

This section provides a guide to understanding the focus of each document of the Corporate Amendments Application. However, documents typically serve multiple purposes. Therefore, it is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents. Please contact the states individually if there are questions about a specific document.

All forms required for the Corporate Amendments Application are located under the Corporate Amendment Application tab in the UCAA Forms Section on the UCAA website. All Forms are in Excel, Word or Adobe PDF file format.

Please read the following Instructions before proceeding in completing Corporate Amendments Application Section VI.

Instructions

The Applicant Company should complete the Corporate Amendments Application Section VI as a courtesy filing in conjunction with other changes or to notify regulatory officials of address changes or contact person changes applicable to the Applicant Company.

Table of Contents

1. Application Form and Attachments
2. State-Specific Information

1. Application Form and Attachments

The Change of Address/Contact Notification is located on the UCAA website. Submit a completed Change of Address/Contact Notification (Form 14).

2. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can amend a Certificate of Authority. Before completing a UCAA Corporate Amendments Application, the Applicant Company should review a listing of requirements for the application state. State-specific requirements are located on the UCAA website. Attach a completed Form 12, Uniform Consent to Service of Process, if the forwarding address has changed because of this application. Include as Item 2 of the application.

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Corporate Amendments Application Section VII
Filing Requirements (Merger of Two or More Foreign Insurers)

This section provides a guide to understanding the focus of each document of the Corporate Amendments Application. However, documents typically serve multiple purposes. Therefore, it is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents. Please contact the states individually if there are questions about a specific document.

Please read the following Instructions before proceeding in completing Corporate Amendments Application Section VII. Section VII may not be applicable.

Instructions

The Corporate Amendments Application Section VII is for notifying the states that a merger involving one or more licensed companies is taking place. Section VII provides for submission of the information on the surviving Applicant Company that changed due to the merger and the surrender of any certificates of authority for non-surviving companies if applicable. Section VII is not applicable for filing in a state if either insurer involved in the merger is a domestic insurer in that state. If an insurer that is party to the merger has a license in California, then do not submit a UCAA Corporate Amendment VII to California, as it has a state application for prior consent of a merger involving a licensed insurer.

For each admitted state for any one of the merging companies, please proceed through the steps given below to determine the appropriate filing for the situation in each state. The steps may result in one Corporate Amendment filing going to several states to report the merger and filing to add lines of business if the surviving entity is not currently authorized to transact a line of business absorbed by the non-surviving entity. That filing would include corporate documents that changed due to the merger, if any, and surrender of the non-surviving company's Certificate of Authority if applicable. In some cases, the Applicant Company may need to submit the UCAA expansion application to some states to obtain a license that allows the surviving insurance company to operate.

Step One:

For each state consider the following:

1. Is the surviving insurer licensed as a foreign insurer in the state?

2. Is the non-surviving insurer licensed as a foreign insurer in the state?

   If the answer to both questions is "yes," then proceed to Step Two.

   If the answer to both questions is "no," then no filing in the state is required. Do not complete the UCAA Corporate Amendments Application. In order to conduct business in the state post-merger, the surviving insurer will need to complete the UCAA Expansion Application located on the UCAA website.

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If the answer to question one is "yes" and the answer to question two is "no," then go to Step Two. If the answer to question one is "no" the surviving insurer is not currently authorized as a foreign insurer in the state, then go to Step Three.

Step Two:

For the authorized surviving Applicant Company:

1. Are the authorized lines of business aligned for the merged companies?

2. Is the surviving Applicant Company currently authorized to write all of these lines of business, including variable products, in the state, formerly conducted by the non-survivor?

   If the answer to questions 1 and 2 is "yes," then complete Section VII of the UCAA Corporate Amendments Application.

   If the answer to either question is "no," then review and complete both Section VII and Section II of the UCAA Corporate Amendments Application located on the UCAA website to add those lines that the Surviving Applicant Company is not currently authorized to transact in the state. For additional guidance please refer to the UCAA FAQs – General.

Step Three:

If the instructions directed the Applicant Company to this step, then the surviving Applicant Company is not currently authorized to conduct business in the state. In order to conduct business in the state, the surviving Applicant Company must complete the UCAA Expansion Application and request authorization for all lines it will be transacting in the state, post merger. For further information and clarification, please contact the individual listed as the contact for the state for the UCAA Expansion Application.

Table of Contents

1. Application Form and Attachments
2. Filing Fee
3. Articles of Incorporation/Articles of Merger
4. Bylaws
5. Minimum Capital and Surplus Requirements
6. Statutory Deposit Requirements
7. Plan of Operation
8. Statutory Membership(s)
9. NAIC Biographical Affidavits
10. Service of Process
11. State of Domicile Approval
12. State-Specific Information

1. Application Form and Attachments

The Applicant Company must submit a completed Checklist (Form 1C), an original executed Application (Form 2C) and the Applicant Company's original Certificate of Authority or an

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Affidavit of Lost Certificate of Authority (Form 15) as Item 1 of the application. A cover letter may be included as a component of Item 1 of the application.

2. Filing Fee

The application will need to include a filing fee for the state to which the Applicant Company is submitting. The payee name and the instructions for submitting the filing fee are included in the Filing Fees - Corporate Amendments chart located on the UCAA website. Submit a copy of the Applicant Company's check as Item 2 of the application.

3. Articles of Incorporation /Articles of Merger

Indicate the location of the language within the Articles of Incorporation of the surviving Applicant Company that reflects the merger (e.g., page number, section number, etc., of the Articles of Incorporation). In addition:

- If the Articles have changed because of this application, then file the amended Articles of Incorporation.
- If the Articles of Incorporation most recently filed in the application state have not changed because of this application, then do not file the Articles of Incorporation. Simply state that the current Articles of Incorporation are already on file in the application state.

Include as Item 3 of the application.

4. Bylaws

The surviving Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed because of this application, then file the amended bylaws.
- If the bylaws most recently filed in the application state have not changed because of this application, then do not file the bylaws. Simply state that the current bylaws are already on file in the application state. Include as Item 4 of the application.

5. Minimum Capital and Surplus Requirements

The application will need to show that subsequent to the merger, the Applicant Company meets the state's statutory minimum capital and surplus requirements for the requested amendment to its Certificate of Authority. Submit an explanation of how the Applicant Company complies with the capital and surplus requirements as Item 5 of the application. In some states, the minimum capital and surplus requirements are determined by the classes of insurance that the Applicant Company is requesting authority to transact and the classes of insurance the Applicant Company is authorized to transact in all other jurisdictions. The level of surplus required will be determined after considering the Applicant Company's product line, operating record and financial condition. Compliance with the statutorily prescribed minimum surplus requirement may not be sufficient for all Applicant Companies. The Minimum Capital and Surplus Requirements chart located on the UCAA website identifies the minimum capital and surplus

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requirements for each Uniform State. This chart also provides a contact person or a link to a state-specific format or RBC requirements and instructions.

6. Statutory Deposit Requirements

A Statutory Deposit may be required for the requested modification. The Statutory Deposit Requirements chart located on the UCAA website provides state-specific requirements and identifies those states that require a Statutory Deposit. Unless otherwise indicated the Statutory Deposit is for the benefit of all policyholders. Please refer to the Certificate of Compliance and Certificate of Deposit Requirements chart on the UCAA website for specific requirements for the date of issuance of the Certificate of Deposit (Form 7) from the file date of the application. The Applicant Company should submit as Item 6 the Certificate of Deposit (Form 7) prepared by its state of domicile.

7. Plan of Operation

If the business plan of the surviving Applicant Company will change because of the merger, submit a Plan of Operation; otherwise, a statement that the business plan will not change will suffice. The Plan of Operation contains two components, a brief narrative and proforma financial statements/projections (Form 13). The narrative should include significant information in support of the application. Projections must support all aspects of the proposed plan of operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections. The proforma is one of three (3) components in the Plan of Operation. The forms are located on the UCAA website under the Corporate Amendment tab. There is a proforma for life, property/casualty, health and title companies. Provide a company-wide, three-year proforma balance sheet and income statement. The proforma workbook should be the same business types as the financial statement blank filed with the NAIC. For the lines requested, provide three-year premium and loss projections by line for the application state. Projections must support all aspects of the proposed Plan of Operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections.

The proforma when applied to the corporate amendment application is projected data. As such, the projected amounts need not balance with historical NAIC financial filings. The projected data, however, should be relevant to the Company's history of growth and losses as contemplated by the NAIC *Accounting Practices and Procedures Manual*.

The proforma should be completed by statutory accounting and financial reporting professionals that should be available to answer any questions or concerns from reviewing regulatory staff. The proforma is completed on an annual basis, typically for a three-year time period, however, some state may require five years. The proforma should start with the first full year of operation that the Applicant Company anticipates actively writing business in the state(s) receiving the application.

Submit the narrative and completed proforma and all attachments as Item 7 of the application.

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8. Statutory Memberships

In some states, the Applicant Company is required to join one or more rating, guaranty or other organizations before transacting insurance. Generally, the Applicant Company's authorized lines of insurance govern statutorily mandated memberships. The Statutory Membership Requirements chart is available on the UCAA website. Please inquire with the application state regarding any statutory memberships the state may require before the Applicant Company can transact business. Submit documentation supporting membership application(s), in states where required, as Item 8 of the application.

9. NAIC Biographical Affidavits

A. The Applicant Company is required to submit an NAIC Biographical Affidavit in connection with pending or future application(s) for licensure or a permit to organize with a department of insurance in one or more states. The Applicant Company must submit an NAIC Biographical Affidavit on behalf of all officers, directors and key managerial personnel of the Applicant Company and individuals with a ten percent (10%), or more, beneficial ownership in the Applicant Company and the Applicant Company's ultimate controlling parent (Affiant).

B. The UCAA defines "Independent Third-Party" as:

(i) A consumer reporting agency ("CRA") overseen by the Federal Trade Commission ("FTC") and, therefore, subject to the FCRA, which have been vetted and is currently on the approved list;

(ii) Has the ability to perform international background investigations; and

(iii) One whose officers and directors have no material affiliation with the Applicant Company other than stock ownership amounting to less than one percent (1%) of total stock outstanding, unless prior approval is given by the department of insurance to which application is being made.

C. The NAIC Biographical Affidavit requests information with respect to your employment history, education, personal information and character. The NAIC Biographical Affidavit also includes the Disclosure and Authorization Concerning Background Reports (the "Disclosure & Authorization Form"). The signature of the Affiant on the Disclosure & Authorization Form permits an Independent Third-Vendor to conduct an independent third-party verification on the Affiant.

D. The NAIC Biographical Affidavit includes three types of the Disclosure & Authorization Form. There are three different Disclosure & Authorization Forms since certain state laws, regulations and rules require different kinds of disclosures and wording within such form. An Affiant must sign the corresponding Disclosure & Authorization Form(s) for the respective state(s) where the affiant has lived or worked within the last ten (10) years. Refer to the Disclosure & Authorization Forms for further information.

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E. The NAIC Biographical Affidavit is used to evaluate the suitability, competency, character and integrity of the Affiant in connection with an Applicant Company's pending or future application(s) for licensure or a permit to organize with a department of insurance in one or more states.

The Independent Third-Party uses information contained in the NAIC Biographical Affidavit as a tool to perform an independent third-party verification to determine an individual's fitness and propriety. The independent third-party verification may contain information bearing on the Affiant's character, general reputation, personal characteristics, mode of living and credit standing (if required by the state). The Independent Third-Party Vendors shall use the independent third-party verification to create a background report (the "Background Report").

F. The Disclosure & Authorization Form is valid for a maximum of one year. Additionally, an Affiant may revoke the authorization at any time by delivering a written revocation to the Applicant Company. Refer to the Disclosure & Authorization Form for further information.

G. The Background Reports are subject to the Fair Credit Reporting Act ("FCRA"). Pursuant to FCRA, the state departments of insurance and an Applicant Company who is seeking admission are "users" of consumer reports. The FCRA requires that the Applicant Company provide the Affiant with a copy of the "Summary of Your Rights Under the Fair Credit Reporting Act." The Applicant Company should provide a copy of the "Summary of Your Rights under the Fair Credit Reporting Act" to each Affiant. This summary can be found at the Federal Trade Commission (FTC) website.

H. The Applicant Company and state departments of insurance are required to comply with FCRA, especially as it relates to confidentiality of the information contained in such consumer reports. To the extent required by law, the states and Third-Party Vendors should maintain the Background Reports procured under the Disclosure & Authorization Form as confidential. A copy of FCRA is located here.

I. The department of insurance in the state where the Applicant Company files, or intends to file an application and the Applicant Company may require the Background Report. An Affiant, who desires a copy of their Background Report, may request a copy from the Applicant Company or the CRA as indicated on the Disclosure & Authorization Form. Refer to the Disclosure & Authorization Form for further information.

J. Please **check state requirements** for those states that require additional background information, such as fingerprints, in place of or in addition to, NAIC Biographical Affidavits. If applying in one of those states, necessary fingerprints and processing fees should be included.

Refer to the UCAA website for a **list of currently approved Independent Third-Party Vendors for Background Reports**.

NAIC Biographical Affidavits must be completed on the most **current form** [**Word** | **PDF**], in effect at the time the affidavit was signed and the affiant shall not sign the Affidavits more than one year before the date the Applicant Company files the application.

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Submit original Biographical Affidavits that contain the Disclosure & Authorization Form to the state department(s) of Insurance as Item 9 of the application.

10. Uniform Consent to Service of Process

If the merger affects any of the information captured on the Uniform Consent to Service of Process and the Resolution Authorizing Appointment of Attorney (Form 12), submit one original fully executed Uniform Consent to Service of Process form or the appropriate state-specific form. Include as Item 10 of the application.

11. State of Domicile Approval

Provide a copy of the approval from the Applicant Company's state of domicile, including a copy of the Merger Agreement, and sample Assumption Certificate, if any. Include as Item 11 of the application.

The Applicant Company must notify the NAIC once the domiciliary state approves the merger prior to preparation of the electronic application. Email approval to: *fdrccreq@naic.org*.

12. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can amend the Certificate of Authority. Before completing a UCAA Corporate Amendments Application, the Applicant Company should review a listing of requirements for the application state. State-specific requirements are on the UCAA website. Include as Item 12 of the application.

Corporate Amendments Application Section VIII
Filing Requirements (Proposed/Completed Change of Control of Foreign Insurers)

This section provides a guide to understanding the main focus of each document of the Corporate Amendments Application. However, documents are typically used for multiple purposes. Therefore, it is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents. Please contact the states individually if there are questions about a specific document.

All forms required for the Corporate Amendments Application are located under the Corporate Amendment Application tab in the UCAA Forms Section in the Forms section on the UCAA website.

Please read the following Instructions before in completing Corporate Amendments Application Section VIII.

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Instructions

The Corporate Amendments Application Section VIII provides for submission of proposed change of control transaction information (proposed transaction) and a second filing of actual information after the change of control is complete (completed transaction). Section VIII is not applicable for filing in a state if the insurer is a domestic insurer in that state.

Table of Contents

1. Application Form and Attachments
2. Filing Fee
3. Articles of Incorporation
4. Bylaws
5. Plan of Operation
6. NAIC Biographical Affidavits
7. Uniform Consent to Service of Process
8. State of Domicile Approval
9. State-Specific Information

1. Application Form and Attachments

A completed checklist (Form 1C), and an original executed application (Form 2C) must be submitted as Item 1 of the application for a proposed transaction and again for a completed transaction. Include the previous and new group code if applicable. All Forms for the Corporate Amendments Application are located in the Forms section on the UCAA website. A cover letter may be included as a component of Item 1 of the application.

2. Filing Fee

The application may need to include a filing fee for the state to which the Applicant Company is submitting. The payee name and the instructions for submitting the filing fee are located in the Filing Fees - Corporate Amendments chart located on the UCAA website.

Submit a copy of the Applicant Company's check as Item 2 of the application.

3. Articles of Incorporation

Indicate the location of the language within the Articles of Incorporation that reflects the change of city (e.g., page number, section number, etc., of the Articles of Incorporation). In addition:

- If the Articles of Incorporation have changed as a result of the change of control, file the amended Articles.
- If the Articles of Incorporation most recently filed in the application state have not changed because of this application, do not file the Articles of Incorporation. Simply state that the current articles are already on file in the application state.

Include as Item 3 of the application.

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4. Bylaws

The Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed because of this application, file the amended bylaws.
- If the bylaws most recently filed in the application state have not changed because of this application, do not file the bylaws. Simply state that the current bylaws are already on file in the application state.

Include as Item 4 of the application.

5. Plan of Operation

If the business plan of the Applicant Company will change as a result of the change of control transaction, a plan of operation must be submitted; otherwise, a statement that the business plan will not change will suffice and should be submitted as Item 5 of the application. The plan of operation is made up of two components; a brief narrative, and proforma financial statements/projections (Form 13). The narrative should include significant information in support of the application. The proforma is one of two (2) components in the Plan of Operation. The forms are located on the UCAA website under the Corporate Amendment tab. There is a proforma for life, property/casualty, health and title companies. Provide a company-wide, three-year proforma balance sheet and income statement. The proforma workbook should be the same business types as the financial statement blank filed with the NAIC. For the lines requested, provide three-year premium and loss projections by line for the application state. Projections must support all aspects of the proposed Plan of Operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections.

The proforma when applied to the corporate amendment application is projected data. As such, the projected amounts need not balance with historical NAIC financial filings. The projected data, however, should be relevant to the Company's history of growth and losses as contemplated by the NAIC *Accounting Practices and Procedures Manual*.

The proforma should be completed by statutory accounting and financial reporting professionals that should be available to answer any questions or concerns from reviewing regulatory staff. The proforma is completed on an annual basis, typically for a three-year time period, however, some state may require five years. The proforma should start with the first full year of operation that the Applicant Company anticipates actively writing business in the state(s) receiving the application.

The proforma (Form 13) is located in the Forms Section on the UCAA website. Submit the narrative and completed proforma and all attachments as Item 5 of the application

6. NAIC Biographical Affidavits

A. The Applicant Company is required to submit an NAIC Biographical Affidavit (**Form 11)** in connection with pending or future application(s) for licensure or a permit to organize with a department of insurance in one or more states. The Applicant Company must submit an NAIC Biographical Affidavit on behalf of all officers, directors and key

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managerial personnel of the Applicant Company and individuals with a ten percent (10%), or more, beneficial ownership in the Applicant Company and the Applicant Company's ultimate controlling parent (Affiant), if the information currently on file with the regulator is not current.

B. The UCAA defines "Independent Third-Party" as:

(i) A consumer reporting agency ("CRA") overseen by the Federal Trade Commission ("FTC") and, therefore, subject to the FCRA, which have been vetted and is currently on the approved list;

(ii) Has the ability to perform international background investigations; and

(iii) One whose officers and directors have no material affiliation with the Applicant Company other than stock ownership amounting to less than one percent (1%) of total stock outstanding, unless prior approval is given by the department of insurance to which application is being made.

C. The NAIC Biographical Affidavit requests information with respect to your employment history, education, personal information and character. The NAIC Biographical Affidavit also includes the Disclosure and Authorization Concerning Background Reports (the "Disclosure & Authorization Form"). The signature of the Affiant on the Disclosure & Authorization Form permits an Independent Third-Party to conduct an independent third-party verification on the Affiant.

D. The NAIC Biographical Affidavit includes three types of the Disclosure & Authorization Form. There are three different Disclosure & Authorization Forms since certain state laws, regulations and rules require different kinds of disclosures and wording within such form. An Affiant must sign the corresponding Disclosure & Authorization Form(s) for the respective state(s) where the affiant has lived or worked within the last ten (10) years. Refer to the Disclosure & Authorization Forms for further information.

E. The NAIC Biographical Affidavit is used to evaluate the suitability, competency, character and integrity of the Affiant in connection with an Applicant Company's pending or future application(s) for licensure or a permit to organize with a department of insurance in one or more states.

The Independent Third-Party uses information contained in the NAIC Biographical Affidavit as a tool to perform an independent third-party verification to determine an individual's fitness and propriety. The independent third-party verification may contain information bearing on the Affiant's character, general reputation, personal characteristics, mode of living and credit standing (if required by the state). The Independent Third-Party Vendors shall use the independent third-party verification to create a background report (the "Background Report").

F. The Disclosure & Authorization Form is valid for a maximum of one year. Additionally, an Affiant may revoke the authorization at any time by delivering a written revocation to the Applicant Company. Refer to the Disclosure & Authorization Form for further information.

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G. The Background Reports are subject to the Fair Credit Reporting Act ("FCRA"). Pursuant to FCRA, the state departments of insurance and an Applicant Company who is seeking admission are "users" of consumer reports. The FCRA requires that the Applicant Company provide the Affiant with a copy of the "Summary of Your Rights Under the Fair Credit Reporting Act." The Applicant Company should provide a copy of the "Summary of Your Rights under the Fair Credit Reporting Act" to each Affiant. This summary can be found at the Federal Trade Commission (FTC) **website**.

H. The Applicant Company and state departments of insurance are required to comply with the FCRA, especially as it relates to confidentiality of the information contained in such consumer reports. To the extent required by law, the states and Independent Third-Party Vendors should maintain the Background Reports procured under the Disclosure & Authorization Form as confidential. A copy of the FCRA is located **here**.

I. The department of insurance in the state where the Applicant Company files, or intends to file, an application and the Applicant Company may require the Background Report. An Affiant who desires a copy of their Background Report may request a copy from the Applicant Company or the CRA as indicated on the Disclosure & Authorization Form. Refer to the Disclosure & Authorization Form for further information.

J. Please **check state requirements** for those states that require additional background information, such as fingerprints, in place of, or in addition to, NAIC Biographical Affidavits. If applying in one of those states, necessary fingerprints and processing fees should be included.

Refer to the UCAA website for a **list of currently approved Independent Third-Party Vendors for Background Reports**.

NAIC Biographical Affidavits must be completed on the most **current form** [Word | PDF], in effect at the time the affidavit was signed and the affiant shall not sign the Affidavits more than one year before the date the Applicant Company files the application.

Submit original Biographical Affidavits that contain the Disclosure & Authorization Form to the state department(s) of Insurance as Item 6 of the application.

7. Uniform Consent to Service of Process

If there are in effect changes to information captured on the Uniform Consent to Service of Process and the Resolution Authorizing Appointment of Attorney (Form 12), submit one original fully executed Uniform Consent to Service of Process form (Form 12) or the appropriate state-specific form for these states: California, Massachusetts, Virginia and Wisconsin. Pennsylvania does not accept Service of Process and does not require Form 12. Include as Item 7 of the proposed transaction or completed transaction application.

If the most recently filed (in the state in which application is being made) Uniform Consent to Service of Process form (Form 12) has not changed, do not file the form. Simply state in Item 7 that the current information is already on file in the state to which this application relates.

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8. State of Domicile Approval

Provide a copy of the approval from the Applicant Company's state of domicile when the change of control is completed. Include as Item 8 of the completed transaction application.

9. State-Specific Information

Some jurisdictions may have additional requirements that must be met before a proposed change of control can be completed. For example, some states require the filing of a Form E (Pre-Acquisition Notification Form Regarding the Potential Competitive Impact of a Proposed Merger or Acquisition by a Non-Domiciliary Insurer Doing Business in this State or by a Domestic Insurer) at least 30 days before the completion of a change of control transaction. In addition some states may require a Holding Company Act Form B amended statement after completion of the change of control transaction. Before completing a UCAA Corporate Amendments Application, the Applicant Company should review a listing of requirements for the state in which application is being made. State-specific information is available on the UCAA website. Include as Item 9 of the application.

Corporate Amendments Application Section IX
Filing Requirements (Amended Articles of Incorporation)

This section provides a guide to understanding the main focus of each document of the Corporate Amendments Application. However, documents are typically used for multiple purposes. Therefore, it is important that applications be complete.

This section is intended for submission of amended Articles of Incorporation that are not a result of changes addressed in other areas of the Corporate Amendment Application (e.g., change in number of shares or par value).

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents. Please contact the states individually if with questions about a specific document.

All forms required for the Corporate Amendments Application are located under the Corporate Amendment Application tab in the UCAA Forms Section in Forms section on the UCAA website.

Table of Contents

1. Application Form and Attachments
2. Filing Fee
3. Articles of Incorporation
4. Bylaws
5. State of Domicile Approval
6. State-Specific Information

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1. Application Form and Attachments

A completed checklist (Form 1C), and an original executed application (Form 2C) must all be submitted as Item 1 of the application. All forms for the Corporate Amendments Application are located in the Forms section on the UCAA website. A cover letter may be included as a component of Item 1 of the application.

2. Filing Fee

The application will need to include a filing fee for the state to which the Applicant Company is submitting. The payee name and the instructions for submitting the filing fee are included in the: Filing Fees - Corporate Amendments chart on the UCAA website.

Submit a copy of the Applicant Company's check as Item 2 of the application.

3. Articles of Incorporation

Indicate the location of the language within the Articles of Incorporation that reflects the change (e.g., page number, section number, etc., of the Articles of Incorporation). Include as Item 3 of the application.

4. Bylaws

The Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed as a result of this application, file the amended bylaws.
- If the most recently filed (in the state in which application is being made) bylaws have not changed as a result of this application, do not file the bylaws. Simply state that the current bylaws are already on file in the state to which this application relates.

Include as Item 4 of the application.

5. State of Domicile Approval (Foreign Insurers Only)

Provide a copy of the amended Articles of Incorporation approval from the Applicant Company's state of domicile. Include as Item 5 of the application.

6. State-Specific Information

Some jurisdictions may have additional requirements that must be met before a Certificate of Authority can be amended. Before completing a UCAA Corporate Amendments Application, the Applicant Company should review a listing of requirements for the state(s) in which application is being made.

Include as Item 6 of the application.

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Corporate Amendments Application Section X
Filing Requirements (Amended Bylaws)

This section provides a guide to understanding the main focus of each document of the Corporate Amendments Application. However, documents are typically used for multiple purposes. Therefore, it is important that applications be complete.

This section is intended for submission of amended bylaws that are not a result of changes addressed in other areas of the Corporate Amendment Application.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents. Please contact the states individually with questions about a specific document.

All forms required for the Corporate Amendments Application are located under the Corporate Amendment Application tab in the UCAA Forms Section on the UCAA website.

Table of Contents

1. Application Form and Attachments
2. Filing Fee
3. Bylaws
4. State of Domicile Approval
5. State-Specific Information

1. Application Form and Attachments

A completed Checklist (Form 1C), and an original executed application (Form 2C) must all be submitted as Item 1 of the application. All forms for the Corporate Amendments Application are located in the Forms section on the UCAA website. A cover letter may be included as a component of Item 1 of the application.

2. Filing Fee

The application will need to include a filing fee for the state to which the Applicant Company is submitting. The payee name and the instructions for submitting the filing fee are included in the Filing Fees - Corporate Amendments chart on the UCAA website.

Submit a copy of the Applicant Company's check as Item 2 of the application.

3. Bylaws

Indicate the location of the language within the bylaws that reflects the change (e.g., page number, section number, etc., of the bylaws).

Include as Item 3 of the application.

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4. State of Domicile Approval (Foreign Insurers Only)

Provide a copy of the amended bylaws approval from the Applicant Company's state of domicile.

Include as item 4 of the application.

5. State-Specific Information

Some jurisdictions may have additional requirements that must be met before a Certificate of Authority can be amended. Before completing a UCAA Corporate Amendments Application, the Applicant Company should review a list of requirements for the state in which application is being made.

Include as Item 5 of the application.

Corporate Amendments Application Section XI
Filing Requirements (Statement of Withdrawal Complete Surrender of Certificate of Authority)

This section provides a guide to understanding the focus of each document of the Corporate Amendments Application. However, there typically are multiple purposes for documents. Therefore, it is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents. Please contact the states individually with questions about a specific document.

All forms required for the Corporate Amendments Application are located under the Corporate Amendment Application tab in the UCAA Forms Section on the UCAA website.

Table of Contents

1. Application Form and Attachments
2. Filing Fee
3. Statement of Withdrawal and Attachments
4. State-Specific Information

1. Application Form and Attachments

The application must identify the reason for withdrawal. Submit a completed Checklist (Form 1C), and the original Certificate of Authority or an affidavit of lost Certificate of Authority (Form 15) as Item 1 of the application. All forms for the Corporate Amendments Application are located on the UCAA website. A cover letter may be included as a component of Item 1 of the application.

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2. Filing Fee

The application must include a filing fee for the application state, if required. The payee name and instructions for submitting a filing fee are located in the Withdrawal Requirements chart located on the UCAA website. Submit a copy of the Applicant Company's check as Item 2 of the application.

3. Statement of Withdrawal and Attachments

The application must include a completed Statement of Withdrawal (Form 17).

Include attachments to the Statement of Withdrawal as Item 3 of the application.

4. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can cancel a Certificate of Authority. Before completing a UCAA Corporate Amendments Application, the Applicant Company should review a listing of requirements for the state to which the Applicant Company is withdrawing. State-specific requirements are located on the UCAA website. Include as Item 4 of the application.

Corporate Amendments Application Section XII
Filing Requirements (Uniform Consent to Service of Process)

This section provides a guide to understanding the focus of a stand-alone Uniform Consent to Service of Process Application. It is important that the application be complete.

Please contact the states individually if there are questions about a specific document that is not noted under the state specific instructions on the UCAA website.

The required form for the stand-alone Uniform Consent to Service of Process Application is located under the Corporate Amendment Application tab in the UCAA Forms Section on the UCAA website. The Form is in Word or Adobe PDF file format. The electronic stand-alone application is located under the Electronic Application link on the UCAA web site and requires a user ID and password to access.

Please read the following Instructions before proceeding in completing Corporate Amendments Application Section XII.

Instructions

The Applicant Company can complete the Uniform Consent to Service of Process Application as a stand-alone filing or in conjunction with any other corporate amendment application (or via the electronic application) where a service of process form is required to notify regulatory officials of service of process changes to the Applicant Company.

Table of Contents

1. Application Form and Attachments
2. Filing Fee

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3. State-Specific Information

1. Application Form

The Uniform Consent to Service of Process is located on the UCAA website. Submit a completed Uniform Consent to Service of Process (Form 12) or utilize the electronic stand-alone application process.

2. Filing Fee

The application will need to include a filing fee if required by the application state. Check the Corporate Amendment Filing Fee chart /Filing Fee Matrix on the UCAA website or contact the application state for filing requirements. If retaliatory, verify fee information via the State Retaliatory Information link. Submit a copy of the Applicant Company's check as Item 2 of the application.

3. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can accept the amended consent to service of process form. Before completing a UCAA Uniform Consent to Service of Process Application, the Applicant Company should review a listing of requirements for the application state. State-specific requirements are located on the UCAA website. Include as Item 3 of the application.

Corporate Amendments Application Section XIII
How to File

To facilitate the prompt review of the Corporate Amendments Application, please ensure that the application adheres to the formatting instructions provided in this section. The states will not accept for filing applications that fail to meet these formatting requirements. Section XIII will address the following areas:

1. Communication Between Applicant Company and Agency
2. Questions
3. Application Checklist
4. Application and Supporting Documents
5. Addresses for Submission of Application
6. Updates/Changes
7. Filing Fee
8. Forms
9. State-Specific Information

1. Communication Between Applicant Company and Agency

Once a state accepts a Corporate Amendments Application for filing, the state will notify the Applicant Company of the official filing date and agency contact person. The state will provide the names, addresses, email (if available) and telephone numbers of the individual(s) assigned to the application.

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Before receiving the name of the agency contact person, an Applicant Company may contact the agency personnel listed on the Addresses and Contact Information for Submission of Application chart located on the UCAA website to obtain information regarding the status of a Corporate Amendments Application.

2. Questions

Section II through Section XII, Filing Requirements, provide detailed guidelines regarding both the type and format of information required for the Corporate Amendments Application. For additional information, or clarification, the Applicant Company may use the contact names provided on the UCAA website.

3. Application Checklist

The Application Checklist (Form 1C) in the Forms section of the UCAA website is a guide for assembling a complete application. Complete the checklist prior to submitting a Corporate Amendments Application for review. Attach a completed checklist to the top of the application.

4. Application and Supporting Documents

Submit one copy of the Checklist, completed application and all supporting documentation to the reviewing state. Louisiana and New York require two (2) complete copies. California requires two (2) complete copies for each change. Each item identified in Section II through Section XII of the Filing Requirements should have a cover sheet as specified below.

Each cover sheet should be on paper suitable for use as a cover sheet, such as binder divider pages.

Tab each cover sheet on the right-hand side of the page with a number corresponding to the document's Item number in the Corporate Amendments Application Checklist.

If a particular item is not included with the cover sheet, attach a written explanation stating the reason the item has not been included to the cover sheet. Below are examples of why the Applicant Company may not attach a particular item to the cover sheet.

- "Item not applicable to this application for the following reason ... (state reason)"
- "Item has been attached separately because of size."

5. Addresses for Submission of Application

Submit the application by mailing it to the appropriate address noted in the Addresses and Contact Information for Submission of Application chart located on the UCAA website.

6. Updates/Changes

The Applicant Company is responsible for informing states of any significant changes that occur or that the Applicant Company discovers during the application review period. Examples of significant changes include: changes in officers and directors, material acquisition or disposal of

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assets, changes in reinsurance, acquisition of the insurer, regulatory actions taken against the insurer, change in current business plan, etc.

The Applicant Company must supply revised forms promptly if any changes occur which materially affect the accuracy of the forms filed in support of the application.

7. Filing Fee

Please see Filing Fees - Corporate Amendments chart and Filing Fees Matrix - Corporate Amendments chart, located on the UCAA website, to determine the correct fee and filing instructions for the application state.

8. Forms

All forms are located on the UCAA website.

9. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can issue an amended Certificate of Authority. Before completing a UCAA Corporate Amendments Application the Applicant Company should review a listing of requirements for the application state located under State-Specific Requirements on the UCAA website.

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Office of Insurance Regulation
Company Admissions

APPLICATION FOR ELIGIBILITY AS A SURPLUS LINES INSURER

Pursuant to Section 626.918(2)(a), Florida Statutes, eligibility of the insurer must be requested in writing by the Florida Surplus Lines Service Office (FSLSO) http://fslso.com. Instructions for registering with the FSLSO are found here. The Office's review of the application does not begin until the entire package, including the letter requesting eligibility, is received from the Florida Surplus Lines Service Office and determined to be complete.

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

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

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

APPLICATION FOR ELIGIBILITY AS A SURPLUS LINES INSURER

INSTRUCTIONS
SECTION I - APPLICATION FORMS & FEES

Section I-1 Written Request for Eligible Surplus Lines Status

A written request must be submitted from the Florida Surplus Lines Service Office requesting the admission of the insurer. The request must detail the lines of insurance the insurer intends to offer (refer to Form OIR-C1-1416) and a projection of how much premium will be written on an annual basis. If the insurer is made eligible to write surplus lines coverages, it will be only for those lines requested.

Additionally, the request must state the number of surplus lines agents to be used, and the agent who will be responsible for the payment of premium tax.

The request should indicate the name of the appropriate individual with the insurer and the surplus lines agent, whom the Office should contact with any questions.

Section I-2 Fingerprint Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-5. Please see Form OIR-C1-938 for instructions. The fingerprint cards are to be submitted at the time of the application filing.

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.

APPLICATION FOR ELIGIBILITY AS A SURPLUS LINES INSURER

INSTRUCTIONS
SECTION II - LEGAL

THE OFFICE OF INSURANCE REGULATION RECOMMENDS THAT CORPORATE DOCUMENTS BE REVIEWED BY YOUR LEGAL COUNSEL. THE OFFICE IS A FILING AGENCY AND AS SUCH DOES NOT RENDER ANY LEGAL, ACCOUNTING OR TAX ADVICE. THE PROFESSIONAL ADVICE OF YOUR LEGAL COUNSEL TO ASCERTAIN EXACT COMPLIANCE WITH ALL STATUTORY REQUIREMENTS IS STRONGLY RECOMMENDED.

Section II-1 Service of Process Consent and Agreement

Provide an executed Uniform Consent to Service of Process, Form OIR-C1-1524.

Section II-2 Certificate of Authority (State of Domicile)

A copy of the state of domicile's certificate of authority showing the lines of business the insurer is authorized to write. This document must bear an original certification by the state of domicile.

Section II-3 United States Trust Fund (Alien Insurers only)

An Alien applicant must submit evidence of a United States trust fund in an amount not less than $5.4 million. This document should be from the trustee of the fund, showing both the amount and nature of the fund, Alien insurers seeking approval for ocean marine and/or aviation risks ONLY are not required to have a United States trust fund (Section 626.918 (2)(g), Florida Statutes).

APPLICATION FOR ELIGIBILITY AS A SURPLUS LINES INSURER

INSTRUCTIONS
SECTION III - FINANCIAL

NOTE: THE INSURER MUST HAVE BEEN AN INSURER FOR NOT LESS THAN THREE YEARS NEXT PRECEDING OR QUALIFY FOR EXEMPTION UNDER SECTION 626.918(2)(b), FLORIDA STATUTES. THE INSURER MUST HAVE A SURPLUS AS TO POLICYHOLDERS NOT LESS THAN $15 MILLION.

Section III-1 Annual Statement

Applicant must file the most recent year end annual statement in the NAIC format. It must contain original signatures of the signing corporate officers and it must be certified by the state of domicile. All schedules must be complete. (Pay special attention to the general interrogatories, notes to financial statements and the organization charts as these schedules are often filed as separate attachments when the annual statement is prepared).

Section III-2 Quarterly Statements

Applicant must file all quarterly financial statements in NAIC format covering the current year-to- date. These statements do not have to be certified by the state of domicile. However, they must be signed by the company's officers and they must be embossed with the insurer's corporate seal. Supplemental loss developmental schedules (also in NAIC format) must be included for each quarter.

Section III-3 Statutory Mandated Examination Reports

Applicant must file its most recent report of examination (certified by state of domicile) performed by its state of domicile, applicant may submit an audited certified public accountant's report prepared on a basis consistent with the insurance laws of the state of domicile, certified by the state of domicile. The report must be statutory, stand-alone. Consolidated reports are not acceptable.

Section III-4 Statutory Financial Statements Audited by Certified Public Accountants

Applicant must provide a copy of the latest Audited Certified Public Accountant's report on the insurer prepared on a basis consistent with the insurance laws of the insurer's state of domicile. If such report does not exist, a statement that no such audit has ever been performed signed by at least two executive officers and embossed with the insurer's corporate seal must be provided.

Section III-5 Previous Florida Business History

In this section the applicant should detail any history that it has had in withdrawing from Florida as a whole or in discontinuing a particular line of business in this state. This statement should include any parent companies or subsidiaries.

APPLICATION FOR ELIGIBILITY AS A SURPLUS LINES INSURER

INSTRUCTIONS
SECTION IV - MANAGEMENT

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

Section IV-1 A listing of all company officers, directors, and shareholders with their respective titles should be listed in this section.

Provide the listing using Form OIR-C1-1298.

Section IV-2 History of Company

A brief history of the company since its incorporation. Include date of incorporation, date commenced business and any changes of ownership or changes in operations, Indicate the number of states licensed, actions taken by governmental agencies that have jurisdiction over the insurer.

Section IV-3 Biographical Affidavits as to Officers, Directors and Shareholders (Form OIR- C1-1423)

A Biographical Affidavit must be completed for each officer, director and shareholder listed in Section IV-1. All questions must be answered and yes answers must be accompanied by an explanation. Each Biographical Affidavit must contain an original signature of the respective officer or director and an original notary seal. Please file an original of each Biographical Affidavit in the order of listing in Section IV-1.

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 page 6 of the NAIC form, 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 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.

APPLICATION AS AN INSURER UNDER FLORIDA'S SURPLUS LINES LAW

INSTRUCTIONS
SECTION IV - MANAGEMENT

Section IV-4 Background Investigative Report

A Background Investigative Report must be provided for each person listed in Section IV-1 above. Background reports must be submitted by the selected background investigation vendor directly to the Office prior to or contemporaneously with the submission of the application filing. Attach confirmation that the reports have been ordered when submitting the application. Please refer to Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports.

Section IV-5 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 or similar type 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 ELIGIBILITY AS A SURPLUS LINES INSURER

CHECK LIST
SECTION I - APPLICATION FORMS

Company: _____

Item#			Completion Check List
1.		Written request from the Florida Surplus Lines Service Office.....	☐
	(a)	All classes of insurance to be transacted listed by code number.....	☐
	(b)	Number of Surplus Lines agents to be used.....	☐
	(c)	Agent responsible for paying premium tax.....	☐
	(d)	Contact persons and phone numbers.....	☐
2.		Fingerprint fee paid electronically	☐
	(a)	Copy of on-line payment confirmation.....	☐

APPLICATION FOR ELIGIBILITY AS A SURPLUS LINES INSURER

CHECK LIST
SECTION II - LEGAL

Company Name: _____

Item #		Completion Check List
1.	Uniform Consent to Service of Process (Form OIR-C1-1524).....	☐
	(a) Signed and dated by	
	1. President or Chief Executive Officer	☐
	2. Secretary.....	☐
	3. Sealed by Company (Corporate Seal).....	☐
2.	Certificate of Authority	☐
	(a) Certification by home state	☐
3.	Evidence of United States Trust Fund.....	☐
	or	
	(a) Explanation as to why this does not apply.....	☐

APPLICATION FOR ELIGIBILITY AS A SURPLUS LINES INSURER

CHECKLIST
SECTION III - FINANCIAL

Company Name: _____

Item #			Completion Check List
1.	Annual Statement		☐
	(a)	Certified by state of domicile	☐
	(b)	Most current year	☐
		1. Signed by two executive officers	☐
		2. Sealed by corporation	☐
		3. Supplemental schedules included	☐
2.	Quarterly Statements		☐
	(a)	All quarterly statements year to date	☐
	(b)	Statements in NAIC format	☐
		1. Signed by two executive officers	☐
		2. Sealed by corporation	☐
3.	Statutory examination by state of domicile		☐
	(a)	Certified by state of domicile	☐
4.	Statutory Financial Statements audited by Certified Public Accountants		☐
	or		
	Statement by the company that no such audit has ever been performed		☐
		1. Signed by Executive Officer	
		2. Sealed by Company (Corporate Seal)	☐
5.	Previous Florida business history statement		☐

APPLICATION FOR ELIGIBILITY AS A SURPLUS LINES INSURER

CHECKLIST
SECTION IV - MANAGEMENT

Company Name: _____

Item#			Completion Check List
1.		Listing of all company officers, directors and shareholders)	☐
	(a)	Full names listed	☐
	(b)	Titles listed	☐
2.		History of company since incorporation	☐
3.		Biographical affidavits as to officers and directors	☐
		As to each biographical:	
	(a)	All blanks filled in	☐
	(b)	All "yes" answers explained	☐
	(c)	Contains original signature of each respective officer and director	☐
	(d)	Notarized (Original)	☐
	(e)	Biographical affidavits completed for all persons listed in Item 1 above	☐
	(f)	Original filed	☐
5.		Background investigative reports for persons listed in Section IV-1	☐
6.		Fingerprint cards completed for each person listed in Section IV-1	☐
	(a)	Contains original signature of each respective officer and director	☐
	(b)	Office of Insurance Regulation card only	☐
	(c)	No erasures or alterations on card	☐

APPLICATION FOR ELIGIBILITY AS A SURPLUS LINES INSURER

CHECKLIST VERIFICATION

The undersigned says that he/she is a senior officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with licensure sought by _____, that he/she has read said application that
(Entity Name)
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

UNIFORM CERTIFICATE OF AUTHORITY APPLICATION

FOR EXPANSION APPLICATION ONLY
FLORIDA SPECIFIC INFORMATION

1. Florida requires fingerprinting of all individuals for which biographical affidavits or business character reports are being submitted. To print or download a copy of the fingerprint card instructions including instructions for submitting fingerprint fees (click here). The fingerprint cards can be obtained from the Applications Coordinator by calling (850) 413-2575 or email to appcoord@floir.com.

Office of Insurance Regulation
Company Admissions

APPLICATION FOR CAPTIVE INSURER

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.

The completed application 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 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 CAPTIVE INSURER
FORM AND INSTRUCTIONS

SECTION A – GENERAL INFORMATION

Name of Proposed Captive:	

Type of Proposed Captive (please check one):	
Pure	
Reinsurance	
Industrial Insured (Include Industry Information)	
Special Purpose (Explain)	

Form of Organization (please check one):	
Stock	
Mutual	
Incorporated Non-Profit	
Other (Explain)	

Principal Place of Business/Location of Books and Records of Proposed Captive; if these are different, provide both addresses. Note, Captive must maintain principal place of business in this state:	

Name and Address of Registered Agent for Service of Process, Name an Individual (in addition to Chief Financial Officer, State of Florida). Include an executed Form OIR C1-1524, Uniform Consent to Service of Process (NAIC Uniform Consent to Service of Process, Form12). http://www.naic.org/industry_ucaa.htm	
Name:	
Address:	
Telephone:	
E-Mail:	
Cell Phone:	

APPLICATION FOR CAPTIVE INSURER
FORM AND INSTRUCTIONS

Name(s) and Address of Parent of Proposed Captive:	
Name:	
Address:	
Telephone:	
E-Mail:	
%Ownership:	

Name(s) and Address of Proposed Beneficial Owner(s) - 10% or more of Proposed Captive:	
Name:	
Address:	
Telephone:	
E-Mail:	
%Ownership:	

Name(s) and Address of Proposed Beneficial Owner(s) - 10% or more of Proposed Captive:	
Name:	
Address:	
Telephone:	
E-Mail:	
%Ownership:	

Name(s) and Address of Proposed Beneficial Owner(s) - 10% or more of Proposed Captive:	
Name:	
Address:	
Telephone:	
E-Mail:	
%Ownership:	
Attach additional sheets/documents, if necessary	

Please explain the relationship among Parent/Beneficial Owner(s). Attach additional sheets/documents, if necessary:	
Provide a copy of the latest Annual Report, 10K, and/or personal financial statements of Parent/Beneficial Owner(s).	
Provide any additional information available or applicable.	

Name, address, and telephone number of individual to be contacted regarding this application:	
Name:	
Address:	
Telephone:	
E-Mail:	
Cell Phone:	
Position or relationship to Proposed Captive:	

[Remainder of this page intentionally left blank]

APPLICATION FOR CAPTIVE INSURER
FORM AND INSTRUCTIONS

Names of Incorporators of Proposed Captive	
Name:	
Address:	
Contact Information:	
Name:	
Address:	
Contact Information:	
Name:	
Address:	
Contact Information:	
Name:	
Address:	
Contact Information:	
Name:	
Address:	
Contact Information:	
Florida Resident Incorporator (At least two Incorporators must be residents of Florida.)	
Name:	
Home Address:	
Contact Information:	
Florida Resident Incorporator (At least two Incorporators must be residents of Florida.)	
Name:	
Home Address:	
Contact Information:	

[Attach additional page if necessary]

Names of Directors of Proposed Captive - Include a Form OIR-C1-1423, Biographical Affidavit (NAIC Biographical Affidavit, Form 11) for each Director. http://www.naic.org/industry_ucaa.htm	
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11
Florida Resident Director (At least one Director must be a resident of Florida.)	
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11

[Attach additional page if necessary]

APPLICATION FOR CAPTIVE INSURER
FORM AND INSTRUCTIONS

Names of Officers of Proposed Captive - Include a Form OIR-C1-1423, Biographical Affidavit (NAIC Biographical Affidavit, Form 11) for each Officer. http://www.naic.org/industry_ucaa.htm	
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11
Position:	
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11
Position:	
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11
Position:	
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11
Position:	
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11
Position:	
Name:	
Home Address:	Include on Form 11
Social Security Number:	Include on Form 11
Position:	

[Attach additional page if necessary]

APPLICATION FOR CAPTIVE INSURER
FORM AND INSTRUCTIONS

SECTION B – FINANCIAL INFORMATION

Section B-1: Sworn Statement:

Proposed Captive must provide a statement sworn under oath by its President and Secretary, showing its financial condition.

Section B-2:

Capital and Surplus (Stock Company):	
Initial Capital	$
Initial Surplus	$
Total	$

Form of Minimum Required Capital and Surplus:	
Identity of Financial Institution:	
Name:	
Address:	
Telephone:	
Officer:	
E-Mail:	
Description of form of capital and surplus:	

Form of Additional Capital and Surplus:	
Identity of Financial Institution:	
Name:	
Address:	
Telephone:	
Officer:	
E-Mail:	
Description of additional capital (cash, cash equivalent, letter of credit, securities invested as provided in Part II of Chapter 625, Florida Statutes):	

APPLICATION FOR CAPTIVE INSURER
FORM AND INSTRUCTIONS

Type of Stocks to be Authorized	Number of Shares:
(1)	
(2)	
(3)	

*Par Value of Each Share by Type:	Selling Price:
(1)	$
(2)	$
(3)	$

*Indicate the Par Value specified in the Articles or provide Board Minutes declaring the stated value of Paid-In Capital.

Location of Shares of Stock:	

Funding (Mutual)	
Amount of Contributed Surplus to Policyholders:	
If Letter(s) of Credit is used for capitalizing/funding proposed Captive, please provide the following (use additional sheets as necessary).	
Amount:	
Name and Address of Financial Institution:	
Issued in Favor of:	FLORIDA OFFICE OF INSURANCE REGULATION

[Remainder of this page intentionally left blank]

SECTION C – BUSINESS PLAN AND OTHER RELATED MATTERS

Section C-1: Plan of Operation

Provide a written business plan that includes an overview of the parent, requested licensing date and a three-year plan of operation that ties directly to the actuarial/feasibility study completed for the proposed Captive. The plan must also include all major areas of the proposed operations as outlined below.

(A) Management

Provide a brief description of the management experience, expertise, and character of each individual (by name) involved in the management of the proposed Captive including the following areas: marketing, underwriting, rating, reserving, reinsurance, claims handling, accounting, and investments. This includes any outside experts, consultants or service providers to be utilized by management on an ongoing basis.

(B) Insurance Products

Submit a description of each line of insurance to be written and the types of risks contained within, including policy limits and deductibles. In addition, utilize Form OIR-C1-1416, Uniform Certificate of Authority (UCAA) Lines of Insurance form (NAIC UCAA Lines of Insurance, Form 3) available at: http://www.naic.org/industry_ucaa.htm to indicate the particular line(s) of insurance the Captive is proposing to write; complete for Florida only.

(C) Reinsurance

Provide details of the planned use of reinsurance including the purpose of the reinsurance and the degree to which it is to be used in relation to the amount of insurance in force. Include retentions and limits of liability for the proposed reinsurance, as well as catastrophe coverage and the largest amount retained on any one risk.

(D) Pro Forma Financial Statements

Provide pro forma financial statements utilizing Form OIR-DO-896, UCAA ProForma Financial Statements, Property and Casualty Insurance Company (NAIC UCAA ProForma Financial Statements, Form 13), available at: http://www.naic.org/industry_ucaa.htm, for three years, excluding any spreadsheet that requires Nationwide only data. Projections must be provided for each line of insurance proposed to be written. Include the Assumptions underlying the Pro forma. The feasibility study may utilize this template for the Pro forma scenarios described in Section C-3.

APPLICATION FOR CAPTIVE INSURER
FORM AND INSTRUCTIONS

Section C-2: Statement of Proposed Captive's ratio of Assets to risks assumed

Submit a Statement of the quantifiable ratio of the proposed Captive's Assets to the risks it will assume.

Section C-3: Actuarial/Feasibility Study

Submit a professional feasibility study conducted by an independent consultant in support of the overall soundness of the proposed Captive's Plan of Operation, financial viability of the Captive, etc. Pro formas in study should reflect an expected and worst case scenario for at least a three-year period. Include expected premium income and bases for determining. Indicate whether statutory or GAAP.

Section C-4: Evidence of proposed Captive's due diligence in evaluation of its parent, member organizations or industrial insureds loss prevention programs

Submit documentation showing proposed Captive's due diligence with regard to evaluating the adequacy of the loss prevention programs of the parent, member organizations or industrial insureds.

Section C-5: Organization Chart

Submit a diagram of the organizational structure including all parent entities and states of incorporation.

Section C-6: Verification of Funds

To obtain a License in Florida, a Captive Insurer is required to have a minimum paid-in Capital and Surplus as to Policyholders as follows:

Pure captive stock insurer:	$100,000 unimpaired paid-in Capital and $150,000 unimpaired Surplus
Pure captive mutual insurer:	$250,000 unimpaired Surplus
Industrial insured captive stock insurer:	$200,000 unimpaired paid-in Capital and $300,000 unimpaired Surplus
Industrial insured captive mutual insurer:	$500,000 unimpaired Surplus

Special purpose captive insurer:	minimum Net Assets, unimpaired paid-in Capital, and Surplus amounts to be determined by the Office of Insurance Regulation based on Plan of Operation, types of risks to be insured, etc.
Captive reinsurance company:	greater of $300 million capital or unimpaired surplus or 10% of reserves and the Office of Insurance Regulation may prescribe additional capital or surplus based on the type, volume and nature of business transacted.

NOTE: If the Captive Insurer is a not-for-profit corporation, then it must have a minimum Net Assets of at least $250,000. If the Captive Insurer is an industrial insured captive and maintains at least $20 million in unencumbered capital and surplus, it may write workers' compensation and employers liability insurance in excess of $25 million in the annual aggregate.

The funds must be verified by a letter from an officer of the financial institution where the funds are being held and must include the following:

1. Name of depositor and federal identification number;
2. Account numbers and amount of funds in each account;
3. Form of funds on deposit;
4. If funds are a certificate of deposit, include certificate numbers and maturity dates; and
5. Verification that the funds are not encumbered, hypothecated, or pledged.

[Remainder of this page intentionally left blank]

SECTION D – SERVICE PROVIDERS

Captive Management Firm:	
Name:	
Address:	
Telephone:	
E-Mail:	
Contact Person:	

Attorney:	
Name:	
Address:	
Telephone:	
E-Mail:	
Contact Person:	

Claims Administrator:	
Name:	
Address:	
Telephone:	
E-Mail:	
Contact Person:	

Certified Public Accountant:	
Name:	
Address:	
Telephone:	
E-Mail:	
Contact Person:	

APPLICATION FOR CAPTIVE INSURER
FORM AND INSTRUCTIONS

Actuary:	
Name:	
Address:	
Telephone:	
E-Mail:	
Contact Person:	

Reinsurance Broker (Attach copy of Broker of Record Letter):	
Name:	
Address:	
Telephone:	
E-Mail:	
Contact Person:	
Broker Licensing #:	
Primary State of Licensure:	

Reinsurance Intermediary:	
Contact Person:	

Other Service Provider (Explain):	
Name:	
Address:	
Telephone:	
E-Mail:	
Contact Person:	

Other Service Provider (Explain):	
Name:	
Address:	
Telephone:	
E-Mail:	
Contact Person:	

SECTION E – LEGAL DOCUMENTS

Section E-1: Articles of Incorporation

Provide an unexecuted copy of the proposed Captive's Articles of Incorporation. The Office of Insurance Regulation must endorse its approval prior to transmitting to the Florida Secretary of State's office. A license will not be issued to the Captive until the Articles of Incorporation have been certified by the Secretary of State's office and the Office of Insurance Regulation has received an executed copy of the Articles of Incorporation, including a current Florida Certificate of Status. Note, the proposed Captive must have no fewer than three (3) incorporators, of who not fewer than two (2) must be residents of this state. For information concerning the Florida Secretary of State's office, visit www.sunbiz.org

Section E-2: Bylaws

Provide an executed copy of the proposed Captive's Bylaws. These documents must be signed and dated by the secretary of the corporation.

[Remainder of this page intentionally left blank]

SECTION F – INCORPORATORS, OFFICERS, DIRECTORS, 10% OR MORE SHAREHOLDERS

Section F-1: Biographical Affidavits

Provide a Biographical Affidavit, Form OIR-C1-1423, (NAIC Biographical Affidavit, Form 11) for each officer and director listed in Section A. All questions must be answered.

The requirement for the affiant's social security number as part of the Biographical Affidavit is mandatory. However, pursuant to Sections 119.072(1) and (9), 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 NAIC form, 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 119.072(9), 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.

Section F-2: Background Investigative Report

A Background Investigative Report must be provided for each officer and director of the proposed Captive listed in Section A above. Background reports must be submitted by the selected background investigation vendor directly to the Office prior to or contemporaneously with the submission of the application filing. Attach confirmation that the reports have been ordered when submitting the application. Please refer to Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports.

Section F-3: Fingerprint Cards

Provide two fingerprint cards for each officer and director of the proposed Captive listed in Section A above. The fingerprint cards and fees are due at the time the application is filed. **No fingerprint cards, other than those provided by the Office with ORI number FL921400Z, are acceptable**. These cards must be completed at a law enforcement agency and returned to this Office for processing. Include confirmation of fingerprint payment when submitting the application. Please refer to Form OIR-C1-938, Fingerprint Card Instructions. Additional cards are available upon request.

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, Fingerprint Card Instructions.

Section F-4: Attestation of Compliance with Section 628.906, Florida Statutes

Provide an attestation on behalf of the incorporators and stockholder(s) that own 10% or more of the outstanding voting securities of the proposed Captive indicating compliance with Section 626.906, Florida Statutes.

SECTION G – FEES AND OTHER ADMINSTRATIVE MATTERS

Section G-1: Licensing Fee

The proposed Captive must pay an application filing fee of $1,500. Attach a copy of the Application for License - Captive Insurer - Invoice when submitting the application.

Section G-2: EIN#

Provide the EIN# of the Captive insurer.

[Remainder of this page intentionally left blank]

SECTION H – CERTIFICATION

_____
Signature of Officer/Director

_____ _____
Printed Name Printed Title

STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____day of

_____, 20 ___, by _____.

_____
(Signature of Notary Public - State of _____)

(Seal)

_____
(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known ____ OR Produced Identification ___
Type of Identification Produced _____

My Commission expires: _____

APPLICATION FOR LICENSE
CAPTIVE INSURER

INVOICE

Application is hereby made for license as a Captive Insurer 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 Captive_____
2. Business Address_____
3. Federal Employer's I.D. No._____

Accounting Information

B/T	F/T	T/C	AMOUNT
C	F	1006	$1,500.00

STATE OF FLORIDA

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPOINTMENT OF ATTORNEY TO ACCEPT SERVICE

The, _____a Risk Retention Group (called the Group) duly organized under the laws of the State of _____, appoints the Chief Financial Officer of the State of Florida, and his or her successors in office, to be its lawful attorney upon whom all legal process in any action or proceeding against it shall be served and further agrees that any lawful process against it which is served upon this attorney shall have the same legal validity as if served personally upon the Group.

The Group gives the Chief Financial Officer and his or her successors, full authority to do every act necessary to be done under this appointment as fully as the Group could do if personally present, and ratifies all that lawfully do under the power granted by this appointment. This authority may be withdrawn only upon a written notice of revocation and in any case shall continue in effect so long as any liability arising out of this appointment remains outstanding in the State. This instrument is executed pursuant to and shall be construed to constitute full compliance with Section 3(a)(1)(d) of the Liability Risk Retention Act of 1986.

The Group designates (_____) whose
(an individual)
address is (_____) and e-mail

is (_____) as the person to whom process against the Group served upon the Chief Financial Officer shall be forwarded.

IN WITNESS OF THIS APPOINTMENT, said Group, in pursuant to a resolution duly adopted by it's Board of Directors, has caused this instrument to be executed in this manner by its President and Secretary, and its corporate seal to be affixed at the City of _____, State of _____. This ___ day of _____, 20 ____.

Attest:

_____ _____
Secretary (Name of Risk Retention Group)

By

_____
(Corporate Seal) President

OIR-C1-144A
Rev. 5/17
Rule 69O-136.032

DEPARTMENT OF FINANCIAL SERVICES
Office of Insurance Regulation

TRANSMITTAL OF PREMIUM TAXES FOR RISK RETENTION GROUPS (RRG's)

Policy Information:

If policies are from more than one RRG, submit separate transmittal & check for each:

Risk Retention Group Company Name: _____

NAIC #: _____ **and/or FEIN #:** _____

Covering Policies Issued during: _____ **Quarter of 20**____
(1st, 2nd, 3rd, or 4th) (year)

Remittance Information:

Total Gross Premium: $ _____ **Total Tax Remitted (= to 5% Gross Premium) $** _____

Check which one applies:
- ☐ Agency/Agent
- ☐ RRG Company
- ☐ Other

From: _____

Contact for Questions: _____
(Name & Phone # and/or E-mail Address)

MAIL TO: **Florida Department of Financial Services**
Revenue Processing Section
Post Office Box 6100
Tallahassee, FL 32314-6100

FOR DEPARTMENT USE ONLY

		CODE	
AMOUNT	TYPE	CLASS	FEE
	10	04	G
	10	12	P

OIR-A1-1615
Rev 5/17
Rule 69O-136.032

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.402 Exceptions, certificate of authority required.—A certificate of authority shall not be required of an insurer with respect to:

(8)(a) An insurer domiciled outside the United States covering only persons who, at the time of issuance or renewal, are nonresidents of the United States if:
1. The insurer does not solicit, sell, or accept application for any insurance policy or contract to be delivered or issued for delivery to any person in any state;
2. The insurer registers with the office via a letter of notification upon commencing business from this state;
3. The insurer provides the following information, in English, to the office annually by March 1:
a. The name of the insurer; the country of domicile; the address of the insurer's principal office and office in this state; the names of the owners of the insurer and their percentage of ownership; the names of the officers and directors of the insurer; the name, e-mail, and telephone number of a contact person for the insurer; and the number of individuals who are employed by the insurer or its affiliates in this state;
b. The lines of insurance and types of products offered by the insurer;
c. A statement from the applicable regulatory body of the insurer's domicile certifying that the insurer is licensed or registered for those lines of insurance and types of products in that domicile; and
d. A copy of the filings required by the applicable regulatory body of the insurer's country of domicile in that country's official language or in English, if available;
4. All certificates, policies, or contracts issued in this state showing coverage under the insurer's policy include the following statement in a contrasting color and at least 10-point type: "The policy providing your coverage and the insurer providing this policy have not been approved by the Florida Office of Insurance Regulation"; and
5. If the insurer ceases to do business from this state, the insurer will provide written notification to the office within 30 days after cessation.
(b) For purposes of this subsection, "nonresident" means a trust or other entity organized and domiciled under the laws of a country other than the United States or a person who resides in and maintains a physical place of domicile in a country other than the United States, which he or she recognizes as and intends to maintain as his or her permanent home. A nonresident does not include an unauthorized immigrant present in the United States. Notwithstanding any other provision of law, it is conclusively presumed, for purposes of this subsection, that a person is a resident of the United States if such person has:
1. Had his or her principal place of domicile in the United States for 180 days or more in the 365 days prior to issuance or renewal of the policy;
2. Registered to vote in any state;
3. Made a statement of domicile in any state; or
4. Filed for homestead tax exemption on property in any state.
(c) Subject to the limitations provided in this subsection, services, including those listed in the definition of the term "transact" in s. 624.10, may be provided by the insurer or an affiliated person as defined in s. 624.04 under common ownership or control with the insurer.

(d) An alien insurer transacting insurance in this state without complying with this subsection shall be in violation of this chapter and subject to the penalties provided in s. 624.15.

627.954 Rules.—The commission may establish and from time to time amend such rules relating to risk retention groups and purchasing groups as may be necessary or desirable to carry out the provisions of this part.

624.09 "Authorized," "unauthorized" insurer defined.—
(1) An "authorized" insurer is one duly authorized by a subsisting certificate of authority issued by the office to transact insurance in this state.
(2) An "unauthorized" insurer is one not so authorized.

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

624.34 Authority of Department of Law Enforcement to accept fingerprints of, and exchange criminal history records with respect to, certain persons.—
(1) The Department of Law Enforcement may accept fingerprints of organizers, incorporators, subscribers, officers, stockholders, directors, or any other persons involved, directly or indirectly, in the organization, operation, or management of:
(a) Any insurer or proposed insurer transacting or proposing to transact insurance in this state.
(b) Any other entity which is examined or investigated or which is eligible to be examined or investigated under the provisions of the Florida Insurance Code.
(2) The Department of Law Enforcement may accept fingerprints of individuals who apply for a license as an agent, customer representative, adjuster, service representative, navigator, or managing general agent or the fingerprints of the majority owner, sole proprietor, partners, officers, and directors of a corporation or other legal entity that applies for licensure with the department or office under the Florida Insurance Code.
(3) The Department of Law Enforcement may, to the extent provided for by federal law, exchange state, multistate, and federal criminal history records with the department or office for the purpose of the issuance, denial, suspension, or revocation of a certificate of authority, certification, or license to operate in this state.
(4) The Department of Law Enforcement may accept fingerprints of any other person required by statute or rule to submit fingerprints to the department or office or any applicant or licensee regulated by the department or office who is required to demonstrate that he or she has not been convicted of or pled guilty or nolo contendere to a felony or a misdemeanor.
(5) The Department of Law Enforcement shall, upon receipt of fingerprints from the department or office, submit the fingerprints to the Federal Bureau of Investigation to check federal criminal history records.
(6) Statewide criminal records obtained through the Department of Law Enforcement, federal criminal records obtained through the Federal Bureau of Investigation, and local criminal records obtained through local law enforcement agencies shall be used by the department and office for the purpose of issuance, denial, suspension, or revocation of certificates of authority, certifications, or licenses issued to operate in this state.

624.407 Surplus required; new insurers.—

(1) To receive authority to transact any one kind or combinations of kinds of insurance, as defined in part V of this chapter, an insurer applying for its original certificate of authority in this state shall possess surplus as to policyholders at least the greater of:
(a) For a property and casualty insurer, $5 million, or $2.5 million for any other insurer;
(b) For life insurers, 4 percent of the insurer's total liabilities;
(c) For life and health insurers, 4 percent of the insurer's total liabilities, plus 6 percent of the insurer's liabilities relative to health insurance;
(d) For all insurers other than life insurers and life and health insurers, 10 percent of the insurer's total liabilities;
(e) Notwithstanding paragraph (a) or paragraph (d), for a domestic insurer that transacts residential property insurance and is:
1. Not a wholly owned subsidiary of an insurer domiciled in any other state, $15 million.
2. A wholly owned subsidiary of an insurer domiciled in any other state, $50 million; or
(f) Notwithstanding paragraphs (a), (d), and (e), for a domestic insurer that only transacts limited sinkhole coverage insurance for personal lines residential property pursuant to s. 627.7151, $7.5 million.
(2) Notwithstanding subsection (1), a new insurer may not be required to have surplus as to policyholders greater than $100 million.
(3) The requirements of this section shall be based upon all the kinds of insurance actually transacted or to be transacted by the insurer in any and all areas in which it operates, whether or not only a portion of such kinds of insurance are transacted in this state.
(4) As to surplus as to policyholders required for qualification to transact one or more kinds of insurance, domestic mutual insurers are governed by chapter 628, and domestic reciprocal insurers are governed by chapter 629.
(5) For the purposes of this section, liabilities do not include liabilities required under s. 625.041(5). For purposes of computing minimum surplus as to policyholders pursuant to s. 625.305(1), liabilities include liabilities required under s. 625.041(5).

624.408 Surplus required; current insurers.—
(1) To maintain a certificate of authority to transact any one kind or combinations of kinds of insurance, as defined in part V of this chapter, an insurer in this state must at all times maintain surplus as to policyholders at least the greater of:
(a) Except as provided in paragraphs (e), (f), and (g), $1.5 million.
(b) For life insurers, 4 percent of the insurer's total liabilities.
(c) For life and health insurers, 4 percent of the insurer's total liabilities plus 6 percent of the insurer's liabilities relative to health insurance.
(d) For all insurers other than mortgage guaranty insurers, life insurers, and life and health insurers, 10 percent of the insurer's total liabilities.
(e) For property and casualty insurers, $4 million, except for property and casualty insurers authorized to underwrite any line of residential property insurance.
(f) For residential property insurers not holding a certificate of authority before July 1, 2011, $15 million.
(g) For residential property insurers holding a certificate of authority before July 1, 2011, and until June 30, 2016, $5 million; on or after July 1, 2016, and until June 30, 2021, $10 million; on or after July 1, 2021, $15 million.
(h) Notwithstanding paragraphs (e), (f), and (g), for a domestic insurer that only transacts limited sinkhole coverage insurance for personal lines residential property pursuant to s. 627.7151, $7.5 million.

The office may reduce the surplus requirement in paragraphs (f) and (g) if the insurer is not writing new business, has premiums in force of less than $1 million per year in residential property insurance, or is a mutual insurance company.

(2) For purposes of this section, liabilities do not include liabilities required under s. 625.041(5). For purposes of computing minimum surplus as to policyholders pursuant to s. 625.305(1), liabilities include liabilities required under s. 625.041(5).
(3) This section does not require an insurer to have surplus as to policyholders greater than $100 million.
(4) A mortgage guaranty insurer shall maintain a minimum surplus as required by s. 635.042.

624.411 Deposit requirement; domestic insurers and foreign insurers.—
(1) As to domestic insurers, the office shall not issue or permit to exist a certificate of authority unless such insurer has deposited and maintains deposited in trust for the protection of the insurer's policyholders or its policyholders and creditors with the department securities eligible for such deposit under s. 625.52, having at all times a value of not less than as follows:
(a) To transact casualty insurance, $250,000.
(b) To transact all other kinds of insurance, $100,000 per kind of insurance.
(c) A domestic insurer authorized to transact more than one kind of insurance shall not be required to deposit more than $300,000 under this subsection.
(2) As to foreign insurers, the office, upon issuing or permitting to exist a certificate of authority, may require for good cause a deposit and maintenance of the deposit in trust for the protection of the insured's policyholders or its policyholders and creditors with the department securities eligible for such deposit under s. 625.52, having at all times a value of not less than as follows:
(a) To transact casualty insurance, $150,000.
(b) To transact all other kinds of insurance, $100,000 per kind of insurance.
(c) A foreign insurer authorized to transact more than one kind of insurance in this state shall not be required to deposit more than $200,000 under this subsection.
(d) A foreign insurer with surplus as to policyholders of more than $10 million according to its latest annual statement shall not be required to make a deposit under this subsection.
(3) Whenever the office determines that the financial condition of an insurer has deteriorated or that the policyholders' best interests are not being preserved by the activities of an insurer, the office may require such insurer to deposit and maintain deposited in trust with the department for the protection of the insurer's policyholders or its policyholders and creditors, for such time as the office deems necessary, securities eligible for such deposit under s. 625.52, having a market value of not less than the amount which the office determines is necessary, which amount shall be not less than $100,000, or more than 25 percent of the insurer's obligations in this state, as determined from the latest annual financial statement of the insured. The deposit required under this subsection shall not exceed $2 million and is in addition to any other deposits required of an insurer pursuant to subsections (1) and (2) or any other provisions of the Florida Insurance Code.
(4) All such deposits in this state are subject to the applicable provisions of part III of chapter 625.

624.413 Application for certificate of authority.—
(1) To apply for a certificate of authority, an insurer shall file its application therefor with the office, upon a form adopted by the commission and furnished by the office, showing its name; location of its home office and, if an alien insurer, its principal office in the United States; kinds of insurance to be transacted; state or country of domicile; and such additional information as the commission reasonably requires, together with the following documents:
(a) One copy of its corporate charter, articles of incorporation, existing and proposed nonfacultative reinsurance contracts, declaration of trust, or other charter documents, with

all amendments thereto, certified by the public official with whom the originals are on file in the state or country of domicile.
(b) If a mutual insurer, a copy of its bylaws, as amended, certified by its secretary or other officer having custody thereof.
(c) If a foreign or alien reciprocal insurer, a copy of the power of attorney of its attorney in fact and of its subscribers' agreement, if any, certified by the attorney in fact; and, if a domestic reciprocal insurer, the declaration provided for in s. 629.081.
(d) A copy of its financial statement as of December 31 next preceding, containing information generally included in insurer financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally utilized by insurers for financial statements, sworn to by at least two executive officers of the insurer, or certified by the public official having supervision of insurance in the insurer's state of domicile or of entry into the United States. To facilitate uniformity in financial statements, the commission may by rule adopt the form for financial statements approved by the National Association of Insurance Commissioners in 2002, and may adopt subsequent amendments thereto if the form remains substantially consistent.
(e) Supplemental quarterly financial statements for each calendar quarter since the beginning of the year of its application for the certificate of authority, sworn to by at least two of its executive officers. To facilitate uniformity in financial statements, the commission may by rule adopt the form for quarterly financial statements approved by the National Association of Insurance Commissioners in 2002, and may adopt subsequent amendments thereto if the form remains substantially consistent.
(f) If a foreign or alien insurer, a copy of the report of the most recent examination of the insurer certified by the public official having supervision of insurance in its state of domicile or of entry into the United States. The end of the most recent year covered by the examination must be within the 5-year period preceding the date of application. In lieu of the certified examination report, the office may accept an audited certified public accountant's report prepared on a basis consistent with the insurance laws of the insurer's state of domicile, certified by the public official having supervision of insurance in its state of domicile or of entry into the United States.
(g) If a foreign or alien insurer, a certificate of compliance from the public official having supervision of insurance in its state or country of domicile showing that it is duly organized and authorized to transact insurance therein and the kinds of insurance it is so authorized to transact.
(h) If a foreign or alien insurer, a certificate of the public official having custody of any deposit maintained by the insurer in another state in lieu of a deposit or part thereof required in this state under s. 624.411 or s. 624.412, showing the amount of such deposit and the assets or securities of which comprised.
(i) If a life insurer, a certificate of valuation.
(j) If an alien insurer, a copy of the appointment and authority of its United States manager, certified by its officer having custody of its records.
(2) The application shall be accompanied by the applicable fees and license tax as specified in s. 624.501.

624.414 Issuance or refusal of authority.—The fee for filing application for a certificate of authority shall not be subject to refund. The office shall issue to the applicant insurer a proper certificate of authority if it finds that the insurer has met the requirements of this code, exclusive of the requirements relative to the filing and approval of an insurer's policy forms, riders, endorsements, applications, and rates. If it does not so find, the office shall issue its order refusing the certificate. The certificate, if issued, shall specify the kind or kinds and line or lines of insurance the insurer is authorized to transact in this state. The issuance of a certificate of authority does not signify that an insurer has met the requirements of this code relative to the filing and approval of an insurer's policy forms,

riders, endorsements, applications, and rates which may be required prior to an insurer actually writing any premiums.

624.416 Continuance, expiration, reinstatement, and amendment of certificate of authority.—
(4) The office may amend a certificate of authority at any time to accord with changes in the insurer's charter or insuring powers.

624.422 Service of process; appointment of Chief Financial Officer as process agent.—
(1) Each licensed insurer, whether domestic, foreign, or alien, shall be deemed to have appointed the Chief Financial Officer and her or his successors in office as its attorney to receive service of all legal process issued against it in any civil action or proceeding in this state; and process so served shall be valid and binding upon the insurer.
(2) Prior to its authorization to transact insurance in this state, each insurer shall file with the department designation of the name and address of the person to whom process against it served upon the Chief Financial Officer is to be forwarded. The insurer may change the designation at any time by a new filing.
(3) Service of process upon the Chief Financial Officer as the insurer's attorney pursuant to such an appointment shall be the sole method of service of process upon an authorized domestic, foreign, or alien insurer in this state.

624.462 Commercial self-insurance funds.—
(1) Any group of persons may form a commercial self-insurance fund for the purpose of pooling and spreading liabilities of its group members in any commercial property or casualty risk or surety insurance. Any fund established pursuant to subparagraph (2)(a)1. may be organized as a corporation under part I of chapter 607.
(2) As used in ss. 624.460-624.488, "commercial self-insurance fund" or "fund" means a group of members, operating individually and collectively through a trust or corporation, that must be:
(a) Established by:
1. A not-for-profit trade association, industry association, or professional association of employers or professionals which has a constitution or bylaws, which is incorporated under the laws of this state, and which has been organized for purposes other than that of obtaining or providing insurance and operated in good faith for a continuous period of 1 year;
2. A self-insurance trust fund organized pursuant to s. 627.357 and maintained in good faith for a continuous period of 1 year for purposes other than that of obtaining or providing insurance pursuant to this section. Each member of a commercial self-insurance trust fund established pursuant to this subsection must maintain membership in the self-insurance trust fund organized pursuant to s. 627.357;
3. A group of 10 or more health care providers, as defined in s. 627.351(4)(h), for purposes of providing medical malpractice coverage; or
4. A not-for-profit group comprised of one or more community associations responsible for operating at least 50 residential parcels or units created and operating under chapter 718, chapter 719, chapter 720, chapter 721, or chapter 723 which restricts its membership to community associations only and which has been organized and maintained in good faith for the purpose of pooling and spreading the liabilities of its group members relating to property or casualty risk or surety insurance which, in accordance with applicable provisions of part I of chapter 626, appoints resident general lines agents only, and which does not prevent, impede, or restrict any applicant or fund participant from maintaining or selecting an agent of choice. The fund may not refuse to appoint the agent of record for any fund applicant or fund member and may not favor one or more such appointed agents over other appointed agents.

(b)1. In the case of funds established pursuant to subparagraph (a)2. or subparagraph (a)4., operated pursuant to a trust agreement by a board of trustees which shall have complete fiscal control over the fund and which shall be responsible for all operations of the fund. The majority of the trustees shall be owners, partners, officers, directors, or employees of one or more members of the fund. The trustees shall have the authority to approve applications of members for participation in the fund and to contract with an authorized administrator or servicing company to administer the day-to-day affairs of the fund.

2. In the case of funds established pursuant to subparagraph (a)1. or subparagraph (a)3., operated pursuant to a trust agreement by a board of trustees or as a corporation by a board of directors which board shall:

a. Be responsible to members of the fund or beneficiaries of the trust or policyholders of the corporation;

b. Appoint independent certified public accountants, legal counsel, actuaries, and investment advisers as needed;

c. Approve payment of dividends to members;

d. Approve changes in corporate structure; and

e. Have the authority to contract with an administrator authorized under s. 626.88 to administer the day-to-day affairs of the fund, including, but not limited to, marketing, underwriting, billing, collection, claims administration, safety and loss prevention, reinsurance, policy issuance, accounting, regulatory reporting, and general administration. The fees or compensation for services under such contract shall be comparable to the costs for similar services incurred by insurers writing the same lines of insurance, or where available such expenses as filed by boards, bureaus, and associations designated by insurers to file such data. A majority of the trustees or directors shall be owners, partners, officers, directors, or employees of one or more members of the fund.

(3) Each member of a commercial self-insurance trust fund established pursuant to this section, except a fund established pursuant to subparagraph (2)(a)3., must maintain membership in the association or self-insurance trust fund established under s. 627.357. Membership in a not-for-profit trade association, industry association, or professional association of employers or professionals for the purpose of obtaining or providing insurance shall be in accordance with the constitution or bylaws of the association, and the dues, fees, or other costs of membership shall not be different for members obtaining insurance from the commercial self-insurance fund. The association shall not be liable for any actions of the fund nor shall it have any responsibility for establishing or enforcing any policy of the commercial self-insurance fund. Fees, services, and other aspects of the relationship between the association and the fund shall be subject to contractual agreement.

(4) Any financial institution may participate as a member in a commercial self-insurance fund. A financial institution may not require as a condition precedent to making a loan that the prospective borrower insure with any commercial self-insurance fund. Any financial institution participating in a commercial self-insurance fund may participate only for the purpose of providing coverage on the financial institution's direct commercial property and commercial casualty or surety insurance exposures. The financial institution may not participate for the purpose of covering the direct or indirect exposures of its customers.

(5) A commercial self-insurance fund created under subparagraph (2)(a)4. shall be an insurer for the purpose of any assessments levied by the Florida Hurricane Catastrophe Fund as provided under s. 215.555 or by the Citizens Property Insurance Corporation as provided under s. 627.351(6)(b)3. The office shall establish the method for determining the imputed premium that is subject to any such assessment.

(6) A governmental self-insurance pool created pursuant to s. 768.28(16) shall not be considered a commercial self-insurance fund.

624.466 Application requirements for certificate of authority.—All applications for a certificate of authority for a commercial self-insurance fund shall be on a form adopted by the commission and furnished by the office and shall include or have attached the following:
(1) The name of the fund and the location of the fund's principal office, which shall be maintained within this state.
(2) The kinds of insurance initially proposed to be transacted and a copy of each policy, endorsement, and application form it initially proposes to issue or use.
(3) A copy of the constitution, bylaws, or trust agreement which governs the operation of the fund. The constitution, bylaws, or trust agreement shall contain a provision prohibiting any distribution of surplus funds or profit except to members of the fund, as approved by the office pursuant to s. 624.473.
(4) The names and addresses of the trustees of the fund. The office shall not grant or continue approval as to any fund if the office determines any trustee to be incompetent or untrustworthy; that any trustee has been found guilty of, or has pled guilty or no contest to, a felony, a crime involving moral turpitude, or a crime punishable by imprisonment of 1 year or more under the law of any state, territory, or country, whether or not a judgment or conviction has been entered; or that any trustee has had any type of insurance license revoked in this or any other state.
(5) A copy of a properly executed indemnity agreement binding each fund member to individual, several, and proportionate liability as set forth in ss. 624.472 and 624.474.
(6) A plan of risk management which has established measures and procedures to minimize both the frequency and severity of losses.
(7) Proof of competent and trustworthy persons to administer or service the fund in the areas of claims adjusting, underwriting, risk management, and loss control.
(8) Membership applications and the name and address of each member applying for coverage and a current financial statement on each member applying for coverage showing the aggregate net worth of all members to be not less than $500,000, a combined ratio of current assets to current liabilities of more than 1 to 1, and a combined working capital of an amount establishing financial strength and liquidity of the businesses to promptly provide for payment of the normal property or casualty claims proposed to be self-insured.
(9)(a) An initial deposit of cash or securities of the type eligible for deposit by insurers under s. 625.52 in the amount of $100,000.
1. All income from deposits shall belong to the fund and shall be transmitted to the fund as it becomes available.
2. No judgment creditor or other claimant of the fund shall have the right to levy upon any of the assets or securities held as a deposit under this section.
(b) In lieu of the deposit of cash or securities, a fund may file with the office a surety bond in like amount. The bond shall be one issued by an authorized surety insurer, shall be for the same purpose as the deposit in lieu of which it is filed, and shall be subject to the office's approval.
1. No bond shall be approved unless it covers liabilities arising from all policies and contracts issued and entered into during the time the bond is in effect and unless the office is satisfied that the bond provides the same degree of security as would be provided by a deposit of securities.
2. No bond shall be canceled or subject to cancellation unless at least 60 days' advance notice thereof in writing is filed with the office.
(c) Deposits of securities or cash pursuant to this section shall be administered by the office and department in accordance with part III of chapter 625.
(10)(a) Copies of acceptable excess insurance policies written by an insurer or insurers authorized or approved to transact insurance in this state, which excess insurance provides specific and aggregate limits and retention levels satisfactory to the office in accordance with sound actuarial principles. The office may waive this requirement if the fund

demonstrates to the satisfaction of the office that its operation is and will be actuarially sound without obtaining excess insurance.
(b) At least 10 days prior to the proposed effective date of the issuance of any policy, the trustees shall submit proof that the members have paid into a common claims fund in a designated depository cash premiums in an amount of not less than $50,000 or 10 percent of the estimated annual premium of the members at the inception, whichever is greater.
(11) A copy of a fidelity bond or insurance policy from an authorized insurer providing coverage in an amount equal to not less than 10 percent of the funds handled annually and issued in the name of the fund covering its trustees, employees, administrator, or other individuals managing or handling the funds or assets of the fund. In no case may such bond or policy be less than $1,000 or more than $500,000, except that the office may for good cause prescribe an amount in excess of $500,000, subject to the 10-percent limitation of the preceding sentence.
(12)(a) A plan of operation designed to provide sufficient revenues to pay current and future liabilities, as determined in accordance with sound actuarial principles.
(b) A statement prepared by an actuary who is a member of the American Academy of Actuaries or the Casualty Actuarial Society establishing that the fund has prepared a plan of operation which is based on sound actuarial principles. The office shall not approve the fund unless the office determines that the plan established by the fund is designed to provide sufficient revenues to pay current and future liabilities, as determined in accordance with sound actuarial principles.
(13) Such additional information as the commission or office reasonably requires.

624.501 Filing, license, appointment, and miscellaneous fees.—The department, commission, or office, as appropriate, shall collect in advance, and persons so served shall pay to it in advance, fees, licenses, and miscellaneous charges as follows:
(1) Certificate of authority of insurer.
(a) Filing application for original certificate of authority or modification thereof as a result of a merger, acquisition, or change of controlling interest due to a sale or exchange of stock, including all documents required to be filed therewith, filing fee.....$1,500.00
(b) Reinstatement fee.....$50.00
(2) Charter documents of insurer.
(a) Filing articles of incorporation or other charter documents, other than at time of application for original certificate of authority, filing fee.....$10.00
(b) Filing amendment to articles of incorporation or charter, other than at time of application for original certificate of authority, filing fee.....$5.00
(c) Filing bylaws, when required, or amendments thereof, filing fee.....$5.00
(3) Annual license tax of insurer, each domestic insurer, foreign insurer, and alien insurer (except that, as to fraternal benefit societies insuring less than 200 members in this state and the members of which as a prerequisite to membership possess a physical handicap or disability, such license tax shall
be $25).....$1,000.00
(4) Statements of insurer, filing (except when filed as part of application for original certificate of authority), filing fees:
(a) Annual statement.....$250.00
(b) Quarterly statement.....$250.00
(5) All insurance representatives, application for license, application for reinstatement of suspended license, each filing, filing fee.....$50.00
(6) Insurance representatives, property, marine, casualty, and surety insurance.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or unaffiliated agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Customer representative's original appointment and biennial renewal or continuation thereof:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(c) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer or unaffiliated agent making an appointment.....$60.00
(d) Service representatives; managing general agents.

Original appointment and biennial renewal or continuation thereof, each insurer or managing general agent, whichever is applicable.....$60.00

(7) Life insurance agents.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or unaffiliated agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer or unaffiliated agent making an appointment.....$60.00
(8) Health insurance agents.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or unaffiliated agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer or unaffiliated agent making an appointment.....$60.00
(9)(a) Except as provided in paragraph (b), all limited appointments as agent, as provided for in s. 626.321. Agent's original appointment and biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) For all limited appointments as agent, as provided in s. 626.321(1)(c) and (d), the agent's original appointment and biennial renewal or continuation thereof for each insurer is equal to the number of offices, branch offices, or places of business covered by the license multiplied by the fees set forth in paragraph (a).
(10) Fraternal benefit society agents. Original appointment and biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(11) Surplus lines agent. Agent's appointment and biennial renewal or continuation thereof, appointment fee.....$150.00
(12) Adjusters:
(a) Adjuster's original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(b) Nonresident adjuster's original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(c) Emergency adjuster's license, appointment fee.....$10.00
(d) Fee to cover actual cost of credit report, when such report must be secured by department.
(13) Examination—Fee to cover actual cost of examination.
(14) Temporary license and appointment as agent or adjuster, where expressly provided for, rate of fee for each month of the period for which the license and appointment is issued.....$5.00
(15) Issuance, reissuance, reinstatement, modification resulting in a modified license being issued, duplicate copy of any insurance representative license, or an appointment being reinstated.....$5.00
(16) Additional appointment continuation fees as prescribed in chapter 626.....$5.00
(17) Filing application for permit to form insurer as referred to in chapter 628, filing fee.....$25.00
(18) Annual license fee of rating organization, each domestic or foreign organization.....$25.00
(19) Miscellaneous services:

(a) For copies of documents or records on file with the department, commission, or office, per
page.....$ .15
(b) For each certificate of the department, commission, or office under its seal, authenticating any document or other instrument (other than a license or certificate of authority).....$5.00
(c) For preparing lists of agents, adjusters, and other insurance representatives, and for other miscellaneous services, such reasonable charge as may be fixed by the office or department.
(d) For processing requests for approval of continuing education courses, processing fee.....$100.00
(e) Insurer's registration fee for agent exchanging business more than 24 times in calendar year under s. 626.752, s. 626.793, or s. 626.837, registration fee per agent per year.....$30.00
(20) Adjusting firm, original or renewal 3-year license.....$60.00
(21) Limited surety agent or professional bail bond agent, as defined in s. 648.25, each agent and each insurer represented. Original appointment and biennial renewal or continuation thereof, each agent or insurer, whichever is applicable:

Appointment fee.....$44.00

State tax.....24.00

County tax.....12.00

Total.....$80.00

(22) Certain military installations, as authorized under s. 626.322: original appointment and biennial renewal or continuation thereof, each insurer.....$20.00
(23) Filing application for original certificate of authority for third-party administrator or original certificate of approval for a service company, including all documents required to be filed therewith, filing fee.....$100.00
(24) Fingerprinting processing fee—Fee to cover fingerprint processing.
(25) Sales representatives, miscellaneous lines. Original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(26) Reinsurance intermediary:
(a) Application filing and license fee.....$50.00
(b) Original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(27) Title insurance agents:
(a) Agent's original appointment or biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Agency original appointment or biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(c) Filing for title insurance agent's license:

Application for filing, each filing, filing fee.....$10.00

(d) Additional appointment continuation fee as prescribed by s. 626.843.....$5.00
(e) Title insurer and title insurance agency administrative surcharge:
1. On or before January 30 of each calendar year, each title insurer shall pay to the office for each licensed title insurance agency appointed by the title insurer and for each retail office of the insurer on January 1 of that calendar year an administrative surcharge of $200.00.
2. On or before January 30 of each calendar year, each licensed title insurance agency shall remit to the department an administrative surcharge of $200.00.

The administrative surcharge may be used solely to defray the costs to the department and office in their examination or audit of title insurance agencies and retail offices of title insurers and to gather title insurance data for statistical purposes to be furnished to and used by the office in its regulation of title insurance.

(28) Late filing of appointment renewals for agents, adjusters, and other insurance representatives, each appointment.....$20.00

624.610 Reinsurance.—

(11)(a) Any domestic or commercially domiciled insurer ceding directly written risks of loss under this section shall, within 30 days after receipt of a cover note or similar confirmation of coverage, or, without exception, no later than 6 months after the effective date of the reinsurance treaty, file with the office one copy of a summary statement containing the following information about each treaty:
1. The contract period;
2. The nature of the reinsured's business;
3. An indication as to whether the treaty is proportional, nonproportional, coinsurance, modified coinsurance, or indemnity, as applicable;
4. The ceding company's loss retention per risk;
5. The reinsured limits;
6. Any special contract restrictions;
7. A schedule of reinsurers assuming the risks of loss;
8. An indication as to whether payments to the assuming insurer are based on written premiums or earned premiums;
9. Identification of any intermediary or broker used in obtaining the reinsurance and the commission paid to such intermediary or broker if known; and
10. Ceding commissions and allowances.
(b) The summary statement must be signed and attested to by either the chief executive officer or the chief financial officer of the reporting insurer. In addition to the summary

statement, the office may require the filing of any supporting information relating to the ceding of such risks as it deems necessary. If the summary statement prepared by the ceding insurer discloses that the net effect of a reinsurance treaty or treaties (or series of treaties with one or more affiliated reinsurers entered into for the purpose of avoiding the following threshold amount) at any time results in an increase of more than 25 percent to the insurer's surplus as to policyholders, then the insurer shall certify in writing to the office that the relevant reinsurance treaty or treaties comply with the accounting requirements contained in any rule adopted by the commission under subsection (14). If such certificate is filed after the summary statement of such reinsurance treaty or treaties, the insurer shall refile the summary statement with the certificate. In any event, the certificate must state that a copy of the certificate was sent to the reinsurer under the reinsurance treaty.
(c) This subsection applies to cessions of directly written risk or loss. This subsection does not apply to contracts of facultative reinsurance or to any ceding insurer that has a surplus as to policyholders which exceeds $100 million as of the immediately preceding December 31. A ceding insurer otherwise subject to this section which had less than $500,000 in direct premiums written in this state during the preceding calendar year and no more than $250,000 in direct premiums written in this state during the preceding calendar quarter, and which had fewer than 1,000 policyholders at the end of the preceding calendar year, is exempt from this subsection.
(d) An authorized insurer not otherwise exempt from the provisions of this subsection shall provide the information required by this subsection with underlying and supporting documentation upon written request of the office.
(e) The office may, upon a showing of good cause, waive the requirements of this subsection.

625.306 Cash and deposits.—An insurer may have funds in coin or currency of the United States on hand or on deposit in any solvent national or state bank, savings and loan association, or trust company.

626.913 Surplus Lines Law; short title; purposes.—
(1) Sections 626.913-626.937 constitute and may be referred to as the "Surplus Lines Law."
(2) It is declared that the purposes of the Surplus Lines Law are to provide orderly access for the insuring public of this state to insurers not authorized to transact insurance in this state, through only qualified, licensed, and supervised surplus lines agents resident in this state, for insurance coverages and to the extent thereof not procurable from authorized insurers; to protect such authorized insurers, who under the laws of this state must meet certain standards as to policy forms and rates, from unwarranted competition by unauthorized insurers who, in the absence of this law, would not be subject to similar requirements; and for other purposes as set forth in this Surplus Lines Law.
(3) This section, and this Surplus Lines Law, do not apply as to insurance coverages which are subject to s. 626.938.
(4) Except as may be specifically stated to apply to surplus lines insurers, the provisions of chapter 627 do not apply to surplus lines insurance authorized under ss. 626.913-626.937, the Surplus Lines Law.

626.918 Eligible surplus lines insurers.—
(1) A surplus lines agent may not place any coverage with any unauthorized insurer which is not then an eligible surplus lines insurer, except as permitted under subsections (5) and (6).
(2) An unauthorized insurer may not be or become an eligible surplus lines insurer unless made eligible by the office in accordance with the following conditions:

(a) Eligibility of the insurer must be requested in writing by the Florida Surplus Lines Service Office.
(b) The insurer must be currently an authorized insurer in the state or country of its domicile as to the kind or kinds of insurance proposed to be so placed and must have been such an insurer for not less than the 3 years next preceding or must be the wholly owned subsidiary of such authorized insurer or must be the wholly owned subsidiary of an already eligible surplus lines insurer as to the kind or kinds of insurance proposed for a period of not less than the 3 years next preceding. However, the office may waive the 3-year requirement if the insurer provides a product or service not readily available to the consumers of this state or has operated successfully for a period of at least 1 year next preceding and has capital and surplus of not less than $25 million.
(c) Before granting eligibility, the requesting surplus lines agent or the insurer shall furnish the office with a duly authenticated copy of its current annual financial statement in the English language and with all monetary values therein expressed in United States dollars, at an exchange rate (in the case of statements originally made in the currencies of other countries) then-current and shown in the statement, and with such additional information relative to the insurer as the office may request.
(d)1.a. The insurer must have and maintain surplus as to policyholders of not less than $15 million; in addition, an alien insurer must also have and maintain in the United States a trust fund for the protection of all its policyholders in the United States under terms deemed by the office to be reasonably adequate, in an amount not less than $5.4 million. Any such surplus as to policyholders or trust fund shall be represented by investments consisting of eligible investments for like funds of like domestic insurers under part II of chapter 625 provided, however, that in the case of an alien insurance company, any such surplus as to policyholders may be represented by investments permitted by the domestic regulator of such alien insurance company if such investments are substantially similar in terms of quality, liquidity, and security to eligible investments for like funds of like domestic insurers under part II of chapter 625. Clean, irrevocable, unconditional, and evergreen letters of credit issued or confirmed by a qualified United States financial institution, as defined in subparagraph 2., may be used to fund the trust.
b. For those surplus lines insurers that were eligible on January 1, 1994, and that maintained their eligibility thereafter, the required surplus as to policyholders shall be:
(I) On December 31, 1994, and until December 30, 1995, $2.5 million.
(II) On December 31, 1995, and until December 30, 1996, $3.5 million.
(III) On December 31, 1996, and until December 30, 1997, $4.5 million.
(IV) On December 31, 1997, and until December 30, 1998, $5.5 million.
(V) On December 31, 1998, and until December 30, 1999, $6.5 million.
(VI) On December 31, 1999, and until December 30, 2000, $8 million.
(VII) On December 31, 2000, and until December 30, 2001, $9.5 million.
(VIII) On December 31, 2001, and until December 30, 2002, $11 million.
(IX) On December 31, 2002, and until December 30, 2003, $13 million.
(X) On December 31, 2003, and thereafter, $15 million.
c. The capital and surplus requirements as set forth in sub-subparagraph b. do not apply in the case of an insurance exchange created by the laws of individual states, where the exchange maintains capital and surplus pursuant to the requirements of that state, or maintains capital and surplus in an amount not less than $50 million in the aggregate. For an insurance exchange which maintains funds in the amount of at least $12 million for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus in an amount not less than $3 million. If the insurance exchange does not maintain funds in the amount of at least $12 million for the protection of all insurance exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements set forth in sub-subparagraph b.

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

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

2. For purposes of letters of credit under subparagraph 1., the term "qualified United States financial institution" means an institution that:
a. Is organized or, in the case of a United States office of a foreign banking organization, is licensed under the laws of the United States or any state.
b. Is regulated, supervised, and examined by authorities of the United States or any state having regulatory authority over banks and trust companies.
c. Has been determined by the office or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit are acceptable to the office.
(e) The insurer must be of good reputation as to the providing of service to its policyholders and the payment of losses and claims.
(f) The insurer must be eligible, as for authority to transact insurance in this state, under s. 624.404(3).
(g) This subsection does not apply as to unauthorized insurers made eligible under s. 626.917 as to wet marine and aviation risks.
(3) The office shall from time to time publish a list of all currently eligible surplus lines insurers and shall mail a copy thereof to each licensed surplus lines agent at his or her office of record with the office.
(4) This section shall not be deemed to cast upon the office any duty or responsibility to determine the actual financial condition or claims practices of any unauthorized insurer; and the status of eligibility, if granted by the office, shall indicate only that the insurer appears to be sound financially and to have satisfactory claims practices and that the office has no credible evidence to the contrary.
(5) When it appears that any particular insurance risk which is eligible for export, but on which insurance coverage, in whole or in part, is not procurable from the eligible surplus lines insurers, after a search of eligible surplus lines insurers, then the surplus lines agent may file a supplemental signed statement setting forth such facts and advising the office that such part of the risk as shall be unprocurable, as aforesaid, is being placed with named unauthorized insurers, in the amounts and percentages set forth in the statement. Such named unauthorized insurer shall, however, before accepting any risk in this state, deposit with the department cash or securities acceptable to the office and department of the market value of $50,000 for each individual risk, contract, or certificate, which deposit shall be held by the department for the benefit of Florida policyholders only; and the surplus lines agent shall procure from such unauthorized insurer and file with the office a certified copy of its statement of condition as of the close of the last calendar year. If such statement reveals, including both capital and surplus, net assets of at least that amount required for licensure of a domestic insurer, then the surplus lines agent may proceed to consummate such contract of insurance. Whenever any insurance risk, or any part thereof, is placed with an unauthorized insurer, as provided herein, the policy, binder, or cover note shall contain a

statement signed by the insured and the agent with the following notation: "The insured is aware that certain insurers participating in this risk have not been approved to transact business in Florida nor have they been declared eligible as surplus lines insurers by the Office of Insurance Regulation of Florida. The placing of such insurance by a duly licensed surplus lines agent in Florida shall not be construed as approval of such insurer by the Office of Insurance Regulation of Florida. Consequently, the insured is aware that the insured has severely limited the assistance available under the insurance laws of Florida. The insured is further aware that he or she may be charged a reasonable per policy fee, as provided in s. 626.916(4), Florida Statutes, for each policy certified for export." All other provisions of this code shall apply to such placement the same as if such risks were placed with an eligible surplus lines insurer.
(6) When any particular insurance risk subject to subsection (5) is eligible for placement with an unauthorized insurer and not more than 12.5 percent of the risk is so subject, the office may, at its discretion, permit the agent to obtain from the insured a signed statement as indicated in subsection (5). All other provisions of this code apply to such placement the same as if such risks were placed with an eligible surplus lines insurer.

628.041 Applicability of general corporation statutes.—The applicable statutes of this state relating to the powers and procedures of domestic private corporations formed for profit shall apply to domestic stock insurers and to domestic mutual insurers, except:
(1) As to any domestic mutual insurers incorporated pursuant to chapter 617, which chapter shall govern such insurers when in conflict with part I of chapter 607; and
(2) When in conflict with the express provisions of this code.

628.6011 Assessable mutual insurers.—
(1) An "assessable mutual insurer" is an insurer incorporated in Florida without permanent capital stock which has only policyholders, insureds, or risks located in Florida and which transacts insurance only within Florida. An assessable mutual insurer may be formed only in accordance with part I. Members of the assessable mutual have a contingent liability for discharge of its liabilities as provided in this part. An assessable mutual may be authorized to offer only property, health, and casualty insurance.
(2) The assessable mutual shall not participate in the Florida Insurance Guaranty Association or the Florida Life and Health Insurance Guaranty Association.

628.051 Application for permit to form insurer; contents; fee.—
(1) No domestic insurer shall be formed unless the persons so proposing have received a permit from the office.
(2) Written application for such permit shall be filed with the office. Such application and filing shall include:
(a) The name, type, and purpose of insurer.
(b) The name, residence address, business background, and qualifications of each person associated or to be associated in the formation or financing of the insurer. Each such person with an ownership interest of 10 percent or more, or who will hold a position as an officer or director, must furnish on forms adopted by the commission and supplied by the office a sworn biographical statement, legible copies of fingerprints, and authority for release of information in regard to the investigation of such person's background.
(c) A full disclosure of the terms of all understandings and agreements existing or proposed among persons so associated relative to the insurer, or the formation or financing thereof, accompanied by a copy of each such agreement or understanding.
(d) A full disclosure of the terms of all understandings and agreements existing or proposed for management or exclusive agency contracts.

(e) A copy of all proposed articles or certificates of incorporation and proposed bylaws of the proposed insurer.
(f) A copy of all articles or certificates of incorporation of involved corporations, if a copy of the same is not already on file in the office.
(g) A copy of all syndicate, association, firm, partnership, organization, or other similar agreements, by whatever name called, involved in the formation of the proposed insurer or its financing.
(h) If the applicant is a reciprocal insurer, a copy of the power of attorney and of other agreements existing or proposed as affecting investors, subscribers, the attorney in fact, or the applicant.
(i) A copy of any security, or of any proposed document evidencing any right or interest, proposed to be offered.
(j) Such other pertinent information and documents as reasonably requested by the commission or office.
(3) The application shall be accompanied by the filing fee specified in s. 624.501.

628.061 Investigation of proposed organization.—In connection with any proposal to incorporate a domestic insurer, the office shall make an investigation of:
(1) The character, reputation, financial standing, and motives of the organizers, incorporators, and subscribers organizing the proposed insurer.
(2) The character, financial responsibility, insurance experience, and business qualifications of its proposed officers.
(3) The character, financial responsibility, business experience, and standing of the proposed stockholders and directors.

628.071 Granting, denial of permit.—
(1) The office shall expeditiously examine and investigate the application for a permit as referred to in s. 628.051. If the office finds that:
(a) The application is complete;
(b) The documents therewith filed are in compliance with law;
(c) None of the stockholders, organizers, incorporators, subscribers, and other persons who directly or indirectly exercise or have the ability to exercise effective control of the proposed insurer or who will be involved in its management have been found guilty of, or have pleaded guilty or nolo contendere to, a felony or a crime punishable by imprisonment of 1 year or more under the law of the United States or any state thereof, or under the law of any other country, which involves moral turpitude, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases;
(d) The proposed financial structure is adequate; and
(e) All stockholders, organizers, incorporators, subscribers, and other persons who directly or indirectly exercise or have the ability to exercise effective control of the proposed insurer or who will be involved in management of the proposed insurer possess the financial standing and business experience to form an insurer;

it shall issue to the applicant a permit to form the proposed insurer.

(2) If the office does not so find, or finds that the insurer if formed or financed would not be able to qualify for or retain a certificate of authority by reason of the provisions of s. 624.404(3), a permit shall not be granted.
(3) A permit granted under the provisions of this section shall be valid for 1 year from the date of issue, and during any extension of such period, not to exceed an additional year, as may be authorized by the office upon cause shown. The articles of incorporation and all other proceedings thereunder shall become void 1 year from the issue date of such permit

or upon the expiration of such extended period, unless the formation of the proposed insurer has been completed and a certificate of authority has been issued by the office.

628.081 Incorporation of domestic insurer.—
(1) Five or more individuals, none of whom is less than 18 years of age, may incorporate a stock insurer; 10 or more individuals, none of whom is less than 18 years of age, may incorporate a mutual insurer. At least a majority of the incorporators shall be citizens of the United States.
(2) The incorporators shall execute articles of incorporation in triplicate. At least three of them shall acknowledge execution before an officer authorized to take acknowledgments.
(3) The articles of incorporation shall state the purpose for which the corporation is formed and shall state and show:
(a) The name of the corporation.
(b) The duration of its existence, which may be perpetual.
(c) The kinds of insurance which the corporation is formed to transact.
(d) If a stock corporation, its authorized capital stock, the number of shares of stock into which divided, and the par value of each such share, which par value shall be at least $1 but not more than $100.
(e) If a mutual corporation, the maximum contingent liability of its members, other than as to nonassessable policies, for payment of losses and expenses incurred; such liability shall be as stated in the articles of incorporation but shall not be less than 3 nor more than 10 times the premium for the member's policy at the annual premium rate for a term of 1 year.
(f) The number of directors, not less than five, who shall constitute the board of directors and conduct the affairs of the corporation. The term of office of initial directors shall not be for more than 1 year after the date of incorporation.
(g) The name of the county, and the city, town, or place within the county, in which its principal office or principal place of business is to be located in this state.
(h) Such other provisions, not inconsistent with law, deemed appropriate by the incorporators.
(i) The name and residence address of each incorporator and the citizenship of each incorporator who is not a citizen of the United States.

628.091 Filing, approval of articles of incorporation.—
(1) No domestic stock or mutual insurer shall be formed unless its articles of incorporation are approved by the office prior to filing the same with and approval by the Department of State as provided by law.
(2) The incorporators shall file the triplicate originals of the articles of incorporation with the office, accompanied by the filing fee specified in s. 624.501.
(3) The office shall promptly examine the articles of incorporation. If it finds that the articles of incorporation conform to law, and that a permit has been or will be issued, it shall endorse its approval on each of the triplicate originals of the articles of incorporation, retain one copy for its files, and return the remaining copies to the incorporators for filing with the Department of State.
(4) If the office does not so find, it shall refuse to approve the articles of incorporation and shall return the originals.

628.121 Capital stock; amount; payment.—
(1) The articles of incorporation of a stock insurer shall provide for authorized capital in an amount not less than that required under this code.
(2) In the sale of the insurer's capital stock, an amount not less than the minimum paid-in capital stock required under this code shall be paid in with money of the United States or in

equivalent United States Government securities. Any additional sums paid for stock or any stock sold after the minimum required capital has been so paid in in money may be in the form of any type of securities in which the insurer is authorized to invest its funds under part II of chapter 625.

628.151 Insurance business exclusive.—
(1) No domestic insurer shall engage directly or indirectly in any business other than the insurance business and business activities reasonably and necessarily incidental to such insurance business.
(2) A title insurer may also engage in business as an escrow agent; and any insurer may also engage in the business of making, acquiring, selling, dealing in, and servicing of real estate mortgage loans and loans incidental thereto.
(3) A business trust whose declaration of trust was filed with the Secretary of State of Florida prior to January 1, 1959, and which, at the time of the adoption of this code, held a certificate of authority as a title insurer may qualify as an insurer for lawyers' professional liability insurance by complying with the applicable provisions of this code.

628.161 Initial qualifications; mutuals.—
(1) When newly organized, a mutual insurer may be authorized to transact any of the kinds of insurance listed in the schedule contained in subsection (2).
(2)(a) When applying for an initial certificate of authority, the mutual insurer must have unencumbered surplus as to policyholder funds in the amount set out below as minimum initial surplus as to policyholders:
1. With respect to health insurance, $300,000.
2. With respect to property insurance, $200,000.
3. With respect to casualty insurance, $300,000.
4. With respect to any combination of health, property, or casualty insurance, $400,000.
5. With respect to life insurance, $2.5 million.
(b) Thereafter, the mutual insurer must maintain the maintenance level surplus as to policyholders set out below:
1. With respect to health insurance, $200,000.
2. With respect to property insurance, $150,000.
3. With respect to casualty insurance, $200,000.
4. With respect to any combination of health, property, or casualty insurance, $250,000.
5. With respect to life insurance, $1.5 million.
(3) The mutual insurer shall make an initial deposit with the department and thereafter maintain such deposit in an amount equal to one-half the minimum initial surplus as required in paragraph (2)(a), except that with respect to life insurance, the deposit shall be in the amount of $200,000.
(4) Unless a mutual insurer maintains the minimum surplus as to policyholders required by s. 624.408, the mutual insurer must be organized as an assessable mutual insurer subject to the requirements of part II of this chapter.
(5) Deposits required by this section shall be made in compliance with part III of chapter 625. This deposit requirement is in lieu of the requirements of s. 624.411.
(6) A self-insured fund organized under s. 624.4621 and holding a certificate of authority as a self-insurer's fund on December 31, 1993, may become a mutual insurer under this part, pursuant to a plan of reorganization approved by the office. A plan of reorganization must be approved by the office if:
(a) The self-insurer's fund has sufficient financial resources to satisfy all of its obligations under all policies and coverages afforded by the fund before the reorganization and has sufficient financial resources to satisfy all of its other liabilities;
(b) The self-insurer's fund has a minimum of $5 million of surplus;

(c) The self-insurer's fund submits a plan that demonstrates its ability to satisfy the requirements of this chapter pertaining to mutual insurers on an ongoing basis; and
(d) The mutual insurer resulting from the reorganization of the self-insurer's fund retains ownership of all of the assets of the self-insurer's fund, retains all of the liabilities of the self-insurer's fund, and agrees to hold all fund members harmless from any assessment for liabilities of the self-insurer's fund before the date of reorganization.
Upon approval of the plan by the office, any contingent liability of the members or former members of the self-insurer's fund for assessment for losses of the self-insurer's fund is considered satisfied, and all liability for any such contingent assessment is extinguished as of the date the self-insurer's fund becomes an authorized mutual insurer and retains all of the assets and liabilities of the self-insurer's fund.

628.221 Bylaws of mutual insurer.—
(1) The initial board of directors of a domestic mutual insurer shall adopt original bylaws, subject to the approval of the insurer's members at the next succeeding meeting. The members shall have power to make, modify, and revoke bylaws.
(2) The bylaws shall provide:
(a) That each member is entitled to one vote upon each matter coming to a vote at meetings of members, or to more votes in accordance with a reasonable classification of members as set forth in the bylaws and based upon the amount of insurance in force, or upon the amount of the premiums paid by such member, or upon other reasonable factors. A member shall have the right to vote in person or by his or her written proxy. No such proxy shall be made irrevocable or for longer than a reasonable period of time;
(b) For the election of directors by the members and the number, qualifications, terms of office, and powers of the directors;
(c) The time, notice, quorum, and conduct of annual and special meetings of members and voting thereat. The bylaws may provide that the annual meeting shall be held at a place, date, and time to be set forth in the policy and without giving other notice of such meeting;
(d) The number, designation, election, terms, and powers and duties of the respective corporate officer;
(e) For deposit, custody, and disbursement of and accounting for corporate funds;
(f) That a quorum at all annual and special meetings of members will consist of all members present and voting in person or by proxy, after due notice of such meeting;
(g) For any other reasonable provisions customary, necessary, or convenient for the management or regulation of its corporate affairs and not inconsistent with law.
(3) The insurer shall promptly file with the office a copy, certified by the insurer's secretary, of its bylaws and of every modification thereof or addition thereto. The office shall disapprove any bylaw provision deemed by it to be unlawful, unreasonable, inadequate, unfair, or detrimental to the proper interests or protection of the insurer's members or any class thereof. The insurer shall not, after receiving written notice of such disapproval and during the existence thereof, effectuate any bylaw provision so disapproved.

628.231 Directors.—
(1) The affairs of every domestic insurer shall be managed by not less than five directors.
(2) Directors must be elected by the members or stockholders of a domestic insurer at the annual meeting of stockholders or members. Directors may be elected for terms of not more than 3 years each and until their successors are elected and have qualified; and, if to be elected for terms of more than 1 year, the insurer's bylaws shall provide for a staggered-terms system under which the terms of a proportionate part of the members of the board of directors will expire on the date of each annual meeting of stockholders or members.

(3) A majority of the directors must be citizens of the United States.
(4) If so provided in a stock insurer's bylaws, a director of such stock insurer shall be a stockholder thereof; and, if so provided in a mutual insurer's bylaws, a director of such mutual insurer shall be a policyholder thereof.
(5) In discharging his or her duties, a director may consider such factors as the directors deem relevant, including, but not limited to, the long-term prospects and interests of the corporation and its shareholders, the social, economic, legal, or other effects of any action on the employees, suppliers, or policyholders of the corporation or its subsidiaries, the communities and society in which the corporation or its subsidiaries operate, and the economy of the state and the nation. The director may also consider the short-term and long-term interests of the insurer, including, but not limited to, benefits that may accrue to the insured from the insurer's long-term plans, the possibility that such interests may be best served by the continued independence of the insurer, the resources, intent, and past, present, and potential conduct of any person seeking to acquire control of the insurer, and any other relevant factors.

628.251 Management and exclusive agency contracts.—
(1) No domestic mutual insurer or stock insurer shall make any contract whereby any person is granted or is to enjoy in fact the management of the insurer to the substantial exclusion of its board of directors or to have the controlling or preemptive right to produce substantially all insurance business for the insurer, unless the contract is filed with and approved by the office.
(2) Any such contract shall provide that any such manager or producer of its business shall within 90 days after expiration of each calendar year furnish the insurer's board of directors a written statement of amounts received under or on account of the contract and amounts expended thereunder during such calendar year, including the emoluments received therefrom by the respective directors, officers, and other principal management personnel of the manager or producer, and with such classification of items and further detail as the insurer's board of directors may reasonably require.
(3) The office shall disapprove any such contract if it finds that it:
(a) Subjects the insurer to excessive charges;
(b) Is to extend for an unreasonable length of time;
(c) Does not contain fair and adequate standards of performance; or
(d) Contains other inequitable provision or provisions which impair the proper interests of policyholders or members of the insurer.

628.261 Notice of change of director or officer.—An insurer shall give the office written notice of any change of personnel among the directors or principal officers of the insurer within 45 days of such change. The written notice shall include all information necessary to allow the office to determine that the insurer will be in compliance with s. 624.404(3) and at a minimum shall contain the information required by s. 628.051(2)(b), (c), and (d).

628.451 Merger or share exchange of stock insurers and other entities.—
(1) Notwithstanding general limitations on the ability of corporations to merge with other types of entities, a merger may be effected between or among one or more domestic or foreign stock insurers authorized to transact insurance in this state and one or more other entities authorized to transact insurance and self-insurance in this state, including a self-insurance trust fund existing pursuant to s. 627.357, provided, in the case of a merger of a stock insurer with a self-insurance trust fund, that the stock insurer is the surviving entity after the merger, by compliance with the applicable provisions of the statutes of this state governing the merger or share exchange of stock corporations formed for profit and the

applicable provisions of the statutes and regulations of this state governing the merger or share exchange of other entities, including self-insurance trust funds, formed pursuant to the laws of this state, but subject to the special provisions of this section:
(a) A merger or share exchange may be initially proposed at any meeting of the board of directors of a domestic stock insurer by the affirmative vote of two-thirds of the total number of directors of the corporation, or at any meeting of the stockholders of the corporation by the affirmative vote of a majority of the total number of shares of stock outstanding and entitled to vote, provided the notice of such meeting sets forth such proposal.
(b) The plan of merger or share exchange, proposed as required by paragraph (a), shall be submitted to a duly called meeting of the stockholders of record of each domestic stock insurer and may become effective only if adopted at such meeting by the affirmative vote of 75 percent of the total number of shares of stock outstanding and entitled to vote. The notice of such meeting shall set forth in full the proposed plan of merger or share exchange.
(2) No such merger or share exchange shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the office and approved by it. The office shall give such approval provided it finds such plan or agreement:
(a) Is in compliance with law;
(b) Is fair to the stockholders of or other holders of interests in any insurer or self-insurer involved; and
(c) Would not substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this state or elsewhere.
(3) No director, officer, agent, or employee of any insurer party to such merger or share exchange shall receive any fee, commission, compensation, or other valuable consideration whatsoever for in any manner aiding, promoting, or assisting therein except as set forth in such plan or agreement.
(4) Any plan or proposal through which a stock insurer proposes to acquire a controlling stock interest in another stock insurer or other insurance or self-insurance entity through an exchange of stock of the first insurer, issued by the insurer for the purpose, for such controlling stock of or other interests in the second insurer or self-insurer is deemed to be a plan or proposal of merger of the second insurer or self-insurer into the first insurer for the purposes of this section and is subject to the applicable provisions hereof.

628.461 Acquisition of controlling stock.—
(1) A person may not, individually or in conjunction with any affiliated person of such person, acquire directly or indirectly, conclude a tender offer or exchange offer for, enter into any agreement to exchange securities for, or otherwise finally acquire 10 percent or more of the outstanding voting securities of a domestic stock insurer or of a controlling company, unless:
(a) The person or affiliated person has filed with the office and sent to the insurer and controlling company a letter of notification regarding the transaction or proposed transaction within 5 days after any form of tender offer or exchange offer is proposed, or within 5 days after the acquisition of the securities if no tender offer or exchange offer is involved. The notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;
(b) The person or affiliated person has filed with the office the statement as specified in subsection (3). The statement must be completed and filed within 30 days after:
1. Any definitive acquisition agreement is entered;
2. Any form of tender offer or exchange offer is proposed; or
3. The acquisition of the securities, if no definitive acquisition agreement, tender offer, or exchange offer is involved; and

(c) The office has approved the tender or exchange offer, or acquisition if no tender offer or exchange offer is involved, and approval is in effect.

A filing required under this subsection must be made for any acquisition that equals or exceeds 10 percent of the outstanding voting securities.

(2) This section does not apply to any acquisition of voting securities of a domestic stock insurer or of a controlling company by any person who, on July 1, 1976, is the owner of a majority of such voting securities or who, on or after July 1, 1976, becomes the owner of a majority of such voting securities with the approval of the office under this section. The person or affiliated person filing the notice required by paragraph (1)(a) may request, in writing, the office to waive the requirements of paragraph (1)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the insurer. The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the insurer.
(3) The statement to be filed with the office under subsection (1) and furnished to the insurer and controlling company must contain all the following information and any additional information that the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the policyholders and shareholders of the insurer and the public:
(a) The identity of, and the background information specified in subsection (4) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and, if the acquisition is to be made by, or on behalf of, a corporation, association, or trust, as to the corporation, association, or trust and as to any person who controls, directly or indirectly, the corporation, association, or trust, the identity of, and the background information specified in subsection (4) on, each director, officer, trustee, or other natural person performing duties similar to those of a director, officer, or trustee for the corporation, association, or trust.
(b) The source and amount of the funds or other consideration used, or to be used, in making the acquisition.
(c) Any plans or proposals that such persons may have made to liquidate such insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management; and any plans or proposals that such persons may have made to liquidate any controlling company of such insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management.
(d) The number of shares or other securities that the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the securities are to be acquired.
(e) Information as to any contract, arrangement, or understanding with any party with respect to any of the securities of the insurer or controlling company, including, but not limited to, information relating to the transfer of any of the securities, option arrangements, puts or calls, or the giving or withholding of proxies, which information names the party with whom the contract, arrangement, or understanding has been entered into and gives the details thereof.
(f) Effective January 1, 2015, an agreement by the person required to file the statement that the person will provide the annual report specified in s. 628.801(2) if control exists.
(g) Effective January 1, 2015, an acknowledgment by the person required to file the statement that the person and all subsidiaries within the person's control in the insurance holding company system will provide, as necessary, information to the office upon request to evaluate enterprise risk to the insurer.

(4)(a) The information as to the background and identity of each person, which information is required to be furnished pursuant to paragraph (3)(a), shall include:
1. The person's occupations, positions of employment, and offices held during the past 10 years.
2. The principal business and address of any business, corporation, or other organization in which each such office of the person was held or in which each such occupation or position of employment was carried on.
3. Whether the person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.
4. Whether the person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.
5. Whether, during the 10-year period, the person has been the subject of any proceeding under the federal [1]Bankruptcy Act or whether, during the 10-year period, any corporation, partnership, firm, trust, or association in which the person was a director, officer, trustee, partner, or other official has been subject to any such proceeding, either during the time in which the person was a director, officer, trustee, partner, or other official or within 12 months thereafter.
6. Whether, during the 10-year period, the person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law regulating the business of insurance, securities, or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities, or banking, together with details as to any such event.
(b) Any corporation, association, or trust filing the statement required by this section shall give all required information that is within the knowledge of the directors, officers, or trustees (or others performing functions similar to those of a director, officer, or trustee) of the corporation, association, or trust making the filing and of any person controlling either directly or indirectly such corporation, association, or trust. A copy of the statement and any amendments to the statement shall be sent by registered mail to the insurer at its principal office within the state and to any controlling company at its principal office. If any material change occurs in the facts set forth in the statement filed with the office and sent to such insurer or controlling company pursuant to this section, an amendment setting forth such changes shall be filed immediately with the office and sent immediately to such insurer and controlling company.
(5)(a) The acquisition of voting securities shall be deemed approved unless the office disapproves the proposed acquisition within 90 days after the statement required by subsection (1) has been filed. The office may on its own initiate, or if requested to do so in writing by a substantially affected party shall conduct, a proceeding to consider the appropriateness of the proposed filing. The 90-day time period shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10 days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time that it finds an immediate danger to the public health, safety, and welfare of the domestic policyholders exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition temporarily disapproved and any further steps to conclude the acquisition ceased.
(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the insurer unless advance written notice of the change in management is furnished to the office. A

material change in the operation of the insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the insurer. A material change in the management of the insurer is any change in management involving officers or directors of the insurer or any person of the insurer or controlling company having authority to dispose of or obligate 5 percent or more of the insurer's capital or surplus. The office shall approve a material change in operation if it finds the applicable provisions of subsection (7) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (7) have not been met and in such case the insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(6) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:

(a) Willfully violates this section;

(b) In violation of an order of the office issued pursuant to subsection (10), fails to divest himself or herself of any stock obtained in violation of this section, or fails to divest himself or herself of any direct or indirect control of such stock, within 25 days after such order; or

(c) In violation of an order issued by the office pursuant to subsection (10), acquires additional stock of the domestic insurance company or controlling company, or direct or indirect control of such stock, without complying with this section.

(7) The person or persons filing the statement required by subsection (1) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed statement if no proceeding is conducted, that:

(a) Upon completion of the acquisition, the domestic stock insurer will be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the insurer or prejudice the interests of its policyholders or the public;

(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:

1. To liquidate the insurer, sell its assets, or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management; or

2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the insurer

is fair and free of prejudice to the policyholders of the domestic stock insurer or to the public;

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the domestic stock insurer indicate that the acquisition is in the best interest of the policyholders of the insurer and in the public interest;

(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the policyholders of the domestic stock insurer, and in the public interest, to permit such persons to exercise control over such domestic stock insurer;

(f) The officers and directors to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation;

(g) The management of the insurer after the acquisition will be competent and trustworthy and will possess sufficient managerial experience so as to make the proposed operation of the insurer not hazardous to the insurance-buying public;

(h) The management of the insurer after the acquisition will not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto;
(i) The acquisition is not likely to be hazardous or prejudicial to the insurer's policyholders or the public; and
(j) The effect of the acquisition of control would not substantially lessen competition in insurance in this state or would not tend to create a monopoly therein.
(8) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition of any security contrary to the provisions of this section is void. Upon the petition of the domestic stock insurer or controlling company, the circuit court for the county in which the principal office of such domestic stock insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the provisions of this section. There shall be a private right of action in favor of the domestic stock insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the domestic stock insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by such domestic stock insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of a statement pursuant to this section, or who files such a statement, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section, and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.
(9) Any approval by the office under this section does not constitute a recommendation by the office for an acquisition, tender offer, or exchange offer. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.
(10) Upon notification to the office by the domestic stock insurer or a controlling company that any person or any affiliated person of such person has acquired 10 percent or more of the outstanding voting securities of the domestic stock insurer or controlling company without complying with the provisions of this section, the office shall order that the person and any affiliated person of such person cease acquisition of any further securities of the domestic stock insurer or controlling company; however, the person or any affiliated person of such person may request a proceeding, which proceeding shall be convened within 7 days after the rendering of the order for the sole purpose of determining whether the person, individually or in connection with any affiliated person of such person, has acquired 10 percent or more of the outstanding voting securities of a domestic stock insurer or controlling company. Upon the failure of the person or affiliated person to request a hearing within 7 days, or upon a determination at a hearing convened pursuant to this subsection that the person or affiliated person has acquired voting securities of a domestic stock insurer or controlling company in violation of this section, the office may order the person and affiliated person to divest themselves of any voting securities so acquired.
(11)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any insurer or controlling company:
1. The control of which is acquired in violation of this section;
2. That is controlled, directly or indirectly, by any person or any affiliated person of such person who, in violation of this section, has obtained control of a domestic stock insurer or controlling company; or

3. That is controlled, directly or indirectly, by any person who, directly or indirectly, controls any other person who, in violation of this section, acquires control of a domestic stock insurer or controlling company.
(b) If any insurer is subject to suspension or revocation pursuant to paragraph (a), the insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its policyholders, creditors, or stockholders or to the public.
(12)(a) A person may rebut a presumption of control by filing a disclaimer of control with the office on a form prescribed by the office. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. In lieu of such form, a person or acquiring party may file with the office a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to rules 13d-1(b) or 13d-1(c) under the Securities Exchange Act of 1934, as amended. After a disclaimer has been filed, the insurer is relieved of any duty to register or report under this section which may arise out of the insurer's relationship with the person unless the office disallows the disclaimer.
(b) A controlling person of a domestic insurer who seeks to divest the person's controlling interest in the domestic insurer in any manner shall file with the office, with a copy provided to the insurer, confidential notice, not subject to public inspection as provided under s. 624.4212, of the person's proposed divestiture at least 30 days before the cessation of control. The office shall determine those instances in which the party seeking to divest or to acquire a controlling interest in an insurer must file for and obtain approval of the transaction. The information remains confidential until the conclusion of the transaction unless the office, in its discretion, determines that confidential treatment interferes with enforcement of this section. If the statement referred to in subsection (1) is otherwise filed, this paragraph does not apply.
(13) The commission may adopt rules that are necessary to administer this section.

628.4615 Specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.—
(1) For the purposes of this section, the term "specialty insurer" means any person holding a license or certificate of authority as:
(a) A motor vehicle service agreement company authorized to issue motor vehicle service agreements as those terms are defined in s. 634.011;
(b) A home warranty association authorized to issue "home warranties" as those terms are defined in s. 634.301;
(c) A service warranty association authorized to issue "service warranties" as those terms are defined in s. 634.401(13) and (14);
(d) A prepaid limited health service organization authorized to issue prepaid limited health service contracts, as those terms are defined in chapter 636;
(e) An authorized health maintenance organization operating pursuant to s. 641.21;
(f) An authorized prepaid health clinic operating pursuant to s. 641.405;
(g) A legal expense insurance corporation authorized to engage in a legal expense insurance business pursuant to s. 642.021;
(h) A provider that is licensed to operate a facility that undertakes to provide continuing care as those terms are defined in s. 651.011;
(i) A multiple-employer welfare arrangement operating pursuant to ss. 624.436-624.446;
(j) A premium finance company authorized to finance insurance premiums pursuant to s. 627.828; or
(k) A corporation authorized to accept donor annuity agreements pursuant to s. 627.481.
(2) A person may not, individually or in conjunction with any affiliated person of such person, directly or indirectly, conclude a tender offer or exchange offer for, enter into any

agreement to exchange securities for, or otherwise finally acquire, 10 percent or more of the outstanding voting securities of a specialty insurer which is a stock corporation or of a controlling company of a specialty insurer which is a stock corporation; or conclude an acquisition of, or otherwise finally acquire, 10 percent or more of the ownership interest of a specialty insurer which is not a stock corporation or of a controlling company of a specialty insurer which is not a stock corporation, unless:

(a) The person or affiliated person has filed with the office and sent by registered mail to the principal office of the specialty insurer and controlling company a letter of notification regarding the transaction or proposed transaction no later than 5 days after any form of tender offer or exchange offer is proposed, or no later than 5 days after the acquisition of the securities or ownership interest if no tender offer or exchange offer is involved. The notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;

(b) The person or affiliated person has filed with the office an application signed under oath and prepared on forms prescribed by the commission which contains the information specified in subsection (4). The application must be completed and filed within 30 days after any form of tender offer or exchange offer is proposed, or after the acquisition of the securities if no tender offer or exchange offer is involved; and

(c) The office has approved the tender offer or exchange offer, or acquisition if no tender offer or exchange offer is involved.

(3) This section does not apply to any acquisition of voting securities or ownership interest of a specialty insurer or of a controlling company by any person who, on July 9, 1986, is the owner of a majority of such voting securities or ownership interest or who, on or after July 9, 1986, becomes the owner of a majority of such voting securities or ownership interest with the approval of the office under this section. The person or affiliated person filing the required notice in paragraph (2)(a) may request the office to waive the requirements of paragraph (2)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the specialty insurer. The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the specialty insurer.

(4) The application to be filed with the office and furnished to the specialty insurer and controlling company shall contain the following information and any additional information as the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the insureds of the insurer and of the public:

(a)1. The identity of, and the background information specified in subsection (5) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and,

2. If the acquisition is to be made by, or on behalf of, a person other than a natural person and as to any person who controls, either directly or indirectly, such other person, the identity of, and the background information specified in subsection (5) on:

a. Each director, officer, or trustee, if a corporation, or

b. Each partner, owner, manager, or joint venturer, or other person performing duties similar to those of persons in the aforementioned positions, if not a corporation,

for the person.

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

(c) Any plans or proposals which such persons may have made to liquidate the specialty insurer, to sell any of its assets or merge or consolidate it with any person, or to make any

other major change in its business or corporate structure or management; and any plans or proposals which such persons may have made to liquidate any controlling company of the specialty insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management.
(d) The nature and the extent of the controlling interest which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the controlling interest is to be acquired of a specialty insurer or controlling company which is not a stock corporation.
(e) The number of shares or other securities which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the securities are to be acquired.
(f) Information as to any contract, arrangement, or understanding with any party with respect to any of the securities of the specialty insurer or controlling company, including, but not limited to, information relating to the transfer of any of the securities, option arrangements, puts or calls, or the giving or withholding of proxies, which information names the party with whom the contract, arrangement, or understanding has been entered into and gives the details thereof.
(5)(a) The information as to the background and identity of each natural person, which information is required to be furnished pursuant to paragraph (4)(a), shall include:
1. The natural person's occupations, positions of employment, and offices held during the past 10 years.
2. The principal business and address of any business, corporation, or organization in which each such office of the natural person was held, or in which each such occupation or position of employment was carried on.
3. Whether the natural person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.
4. Whether the natural person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.
5. Whether, during the 10-year period, the natural person has been the subject of any proceeding under the federal [1]Bankruptcy Act; or whether, during the 10-year period, any person or other business or organization in which the natural person was a director, officer, trustee, partner, owner, manager, or other official has been subject to any such proceeding, either during the time in which the natural person was a director, officer, or trustee, if a corporation, or a partner, owner, manager, joint venturer, or other official, if not a corporation, or within 12 months thereafter.
6. Whether, during the 10-year period, the natural person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law regulating the business of insurance, securities, or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities, or banking, together with details as to any such event.
7. Fingerprints of each person referred to in subsection (4).
(b) Any person filing the statement required by this section shall give all required information that is within the knowledge of:
1. The directors, officers, or trustees, if a corporation, or
2. The partners, owners, managers, or joint venturers, or others performing functions similar to those of a director, officer, or trustee, if not a corporation,

of the person making the filing and of any person controlling either directly or indirectly such person. If any material change occurs in the facts set forth in the application filed with the office pursuant to this section, an amendment setting forth such changes shall be filed immediately with the office, and a copy of the amendment shall be sent by registered mail to the principal office of the specialty insurer and to the principal office of the controlling company.

(6)(a) The acquisition application shall be reviewed in accordance with chapter 120. The office may on its own initiate, or, if requested to do so in writing by a substantially affected person, shall conduct, a proceeding to consider the appropriateness of the proposed filing. Time periods for purposes of chapter 120 shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10 days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time it finds an immediate danger to the public health, safety, and welfare of the insureds exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition disapproved and any further steps to conclude the acquisition ceased.

(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the specialty insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the specialty insurer unless advance written notice of the change in management is furnished to the office. A material change in the operation of the specialty insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the specialty insurer. A material change in the management of the specialty insurer is any change in management involving officers or directors of the specialty insurer or any person of the specialty insurer or controlling company having authority to dispose of or obligate 5 percent or more of the specialty insurer's capital or surplus. The office shall approve a material change in operations if it finds the applicable provisions of subsection (8) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (8) have not been met and in such case the specialty insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(7) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:

(a) Willfully violates this section;

(b) In violation of an order of the office issued pursuant to subsection (11), fails to divest himself or herself of any stock or ownership interest obtained in violation of this section or fails to divest himself or herself of any direct or indirect control of such stock or ownership interest, within 25 days after such order; or

(c) In violation of an order issued by the office pursuant to subsection (11), acquires an additional stock or ownership interest in a specialty insurer or controlling company or direct or indirect control of such stock or ownership interest, without complying with this section.

(8) The person or persons filing the application required by subsection (2) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed application if no proceeding is conducted, that:

(a) Upon completion of the acquisition, the specialty insurer will be able to satisfy the requirements for the issuance of a license or certificate to write the line of insurance for which it is presently licensed or certificated.

(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the specialty insurer or prejudice the interests of its insureds or the public.

(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:
1. To liquidate the specialty insurer, sell its assets, or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management, or
2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the specialty insurer,

is fair and free of prejudice to the insureds of the specialty insurer or to the public.

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the specialty insurer indicate that the acquisition is in the best interest of the insureds of the insurer and in the public interest.
(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the insureds of the specialty insurer and in the public interest to permit such persons to exercise control over the specialty insurer.
(f) The directors and officers, if such specialty insurer or controlling company is a stock corporation, or the trustees, partners, owners, managers, or joint venturers or other persons performing duties similar to those of persons in the aforementioned positions, if such specialty insurer or controlling company is not a stock corporation, to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation.
(g) The management of the specialty insurer after the acquisition will be competent and trustworthy, and will possess sufficient managerial experience so as to make the proposed operation of the specialty insurer not hazardous to the insurance-buying public.
(h) The management of the specialty insurer after the acquisition shall not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto.
(i) The acquisition is not likely to be hazardous or prejudicial to the insureds of the insurer or to the public.
(j) The effect of the acquisition would not substantially lessen competition in the line of insurance for which the specialty insurer is licensed or certified in this state or would not tend to create a monopoly therein.
(9) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition contrary to the provisions of this section is void. Upon the petition of the specialty insurer or the controlling company, the circuit court for the county in which the principal office of the specialty insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the provisions of this section. There shall be a private right of action in favor of the specialty insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the specialty insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by the specialty insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of an application pursuant to this section, or who files such an application, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.

(10) Any approval by the office under this section does not constitute a recommendation by the office of the tender offer or exchange offer, or acquisition, if no tender offer or exchange offer is involved. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.
(11) If the office determines that any person or any affiliated person of such person has acquired 10 percent or more of the outstanding voting securities of a specialty insurer or controlling company which is a stock corporation, or 10 percent or more of the ownership interest of a specialty insurer or controlling company which is not a stock corporation, without complying with the provisions of this section, the office may order that the person and any affiliated person of such person cease acquisition of the specialty insurer or controlling company and, if appropriate, divest itself of any stock or ownership interest acquired in violation of this section.
(12)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any specialty insurer or controlling company acquired in violation of this section.
(b) If any specialty insurer is subject to suspension or revocation pursuant to paragraph (a), the specialty insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its insureds, creditors, or stockholders or to the public.
(13)(a) For the purpose of this section, the term "acquisition" includes:
1. A tender offer or exchange offer for securities, assets, or other ownership interest;
2. An agreement to exchange securities for other securities, assets, or other ownership interest;
3. A merger of a person or affiliated person into a specialty insurer or a merger of any person with a specialty insurer;
4. A consolidation; or
5. Any other form of change of control

whereby any person or affiliated person acquires or attempts to acquire, directly or indirectly, 10 percent or more of the ownership interest or assets of a specialty insurer or of a controlling company. However, in the case of a health maintenance organization organized as a for-profit corporation, the provisions of s. 628.451 shall govern with respect to any merger or consolidation, and, in the case of a health maintenance organization organized as a not-for-profit corporation, the provisions of s. 628.471 shall govern with respect to any merger or consolidation.

(b) For the purpose of this section, the term "affiliated person" of another person includes:
1. The spouse of such other natural person;
2. The parents of such other natural person and their lineal descendants and the parents of such other natural person's spouse and their lineal descendants;
3. Any person who directly or indirectly owns or controls, or holds with power to vote, 10 percent or more of the outstanding voting securities of such other person;
4. Any person who directly or indirectly owns 10 percent or more of the outstanding voting securities which are directly or indirectly owned or controlled, or held with power to vote, by such other person;
5. Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;
6. Any director, officer, trustee, partner, owner, manager, joint venturer, or employee, or other person performing duties similar to those of persons in the aforementioned positions, of such other person;

7. If such other person is an investment company, any investment adviser of such company or any member of an advisory board of such company;
8. If such other person is an unincorporated investment company not having a board of directors, the depositor of such company; or
9. Any person who has entered into an agreement, written or unwritten, to act in concert with such other person in acquiring, or limiting the disposition of, securities of a specialty insurer or controlling company which is a stock corporation or in acquiring, or limiting the disposition of, an ownership interest of a specialty insurer or controlling company which is not a stock corporation.
(c) For the purposes of this section, the term "controlling company" means any corporation, trust, or association owning, directly or indirectly, 25 percent or more of the voting securities of one or more specialty insurance companies which are stock corporations, or 25 percent or more of the ownership interest of one or more specialty insurance companies which are not stock corporations.
(d) For the purpose of this section, the term "natural person" means an individual.
(e) For the purpose of this section, the term "person" includes a natural person, corporation, association, trust, general partnership, limited partnership, joint venture, firm, proprietorship, or any other entity which may hold a license or certificate as a specialty insurer.
(14) The commission may adopt, amend, or repeal rules that are necessary to implement the provisions of this section, pursuant to chapter 120.

628.471 Mergers; mutual insurers.—
(1) A domestic mutual insurer shall not merge with a stock insurer.
(2) A domestic mutual insurer may merge with another mutual insurer under the applicable procedures prescribed by the statutes of this state applying to corporations formed for profit, except as hereinbelow provided.
(3) The plan and agreement for merger shall be submitted to and approved by at least two-thirds of the members of each mutual insurer voting thereon at meetings called for the purpose pursuant to such reasonable notice and procedure as has been approved by the office. If a life insurer, the right to vote may be limited to members whose policies are other than term and group policies and have been in effect for more than 1 year.
(4) No such merger shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the office and approved by it. The office shall give such approval unless it finds such plan or agreement:
(a) Is inequitable to the policyholders of any domestic insurer involved; or
(b) Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this state and elsewhere.

628.905 Licensing; authority.—
(1) A captive insurance company, if permitted by its charter or articles of incorporation, may apply to the office for a license to do any and all insurance authorized under the insurance code, other than workers' compensation and employer's liability, life, health, personal motor vehicle, and personal residential property insurance, except that:
(a) A pure captive insurance company may not insure any risks other than those of its parent, affiliated companies, controlled unaffiliated businesses, or a combination thereof.
(b) An industrial insured captive insurance company may not insure any risks other than those of the industrial insureds that comprise the industrial insured group and their affiliated companies, or its stockholders or members, and affiliates thereof, of the industrial insured captive, or the stockholders or affiliates of the parent corporation of the industrial insured captive insurance company.
(c) A special purpose captive insurance company may insure only the risks of its parent.

(d) A captive insurance company may not accept or cede reinsurance except as provided in this part.
(e) An industrial insured captive insurance company with unencumbered capital and surplus of at least $20 million may be licensed to provide workers' compensation and employer's liability insurance in excess of $25 million in the annual aggregate. An industrial insured captive insurance company must maintain unencumbered capital and surplus of at least $20 million to continue to write such excess workers' compensation insurance in Florida.
(2) To conduct insurance business in this state, a captive insurance company must:
(a) Obtain from the office a license authorizing it to conduct insurance business in this state;
(b) Hold at least one board of directors' meeting each year in this state;
(c) Maintain its principal place of business in this state; and
(d) Appoint a resident registered agent to accept service of process and to otherwise act on its behalf in this state. In the case of a captive insurance company formed as a corporation or a nonprofit corporation, if the registered agent cannot with reasonable diligence be found at the registered office of the captive insurance company, the Chief Financial Officer of this state must be an agent of the captive insurance company upon whom any process, notice, or demand may be served.
(3) Before receiving a license, a captive insurance company formed as a corporation or a nonprofit corporation must file with the office a certified copy of its articles of incorporation and bylaws, a statement under oath of its president and secretary showing its financial condition, and any other statements or documents required by the office. In addition, an applicant captive insurance company must file with the office evidence of:
(a) The amount and liquidity of the proposed captive insurance company's assets relative to the risks to be assumed;
(b) The adequacy of the expertise, experience, and character of the person or persons who will manage the company;
(c) The overall soundness of the company's plan of operation;
(d) The adequacy of the loss prevention programs of the company's parent, member organizations, or industrial insureds, as applicable; and
(e) Any other factors considered relevant by the office in ascertaining whether the company will be able to meet its policy obligations.
(4) A captive insurance company or captive reinsurance company must pay to the office a nonrefundable fee of $1,500 for processing its application for license.
(a) A captive insurance company or captive reinsurance company must also pay an annual renewal fee of $1,000.
(b) The office may charge a fee of $5 for any document requiring certification of authenticity or the signature of a representative of the office.
(5) If the office is satisfied that the documents and statements filed by the captive insurance company comply with this chapter, the office may grant a license authorizing the company to conduct insurance business in this state until the next succeeding March 1, at which time the license may be renewed.
(6) Upon approval of the office, a foreign or alien captive insurance company may become a domestic captive insurance company by complying with all of the requirements of law relative to the organization and licensing of a domestic captive insurance company of the same or equivalent type in this state and by filing with the Secretary of State its charter or other organizational documents, together with any appropriate amendments that have been adopted in accordance with the laws of this state to bring the charter or other organizational documents into compliance with the laws of this state, along with a certificate of good standing issued by the office. The captive insurance company is then entitled to the necessary or appropriate certificates and licenses to continue transacting business in this state and is subject to the authority and jurisdiction of this state. In connection with this

redomestication, the office may waive any requirements for public hearings. It is not necessary for a captive insurance company redomesticating into this state to merge, consolidate, transfer assets, or otherwise engage in any other reorganization, other than as specified in this section.
(7) An industrial insured captive insurance company need not be incorporated in this state if it has been validly incorporated under the laws of another jurisdiction.

629.071 Surplus funds required.—
(1) A domestic reciprocal insurer hereunder formed, if it has otherwise complied with the applicable provisions of this code, may be authorized to transact insurance if it has and thereafter maintains surplus funds of not less than $250,000.
(2) In addition to the surplus required to be maintained under subsection (1), the insurer shall have, when first so authorized, an expendable surplus of not less than $750,000.

629.081 Organization of reciprocal insurer.—
(1) Twenty-five or more persons domiciled in this state may organize a domestic reciprocal insurer and make application to the office for a certificate of authority to transact insurance.
(2) The proposed attorney shall fulfill the requirements of and shall execute and file with the office, when applying for a certificate of authority, a declaration setting forth:
(a) The name of the insurer;
(b) The location of the insurer's principal office, which shall be the same as that of the attorney and shall be maintained within this state;
(c) The kinds of insurance proposed to be transacted;
(d) The names and addresses of the original subscribers;
(e) The designation and appointment of the proposed attorney and a copy of the power of attorney;
(f) The names and addresses of the officers and directors of the attorney, if a corporation, or of its members, if other than a corporation;
(g) The powers of the subscribers' advisory committee, and the names and terms of office of the members thereof;
(h) That all moneys paid to the reciprocal shall, after deducting therefrom any sum payable to the attorney, be held in the name of the insurer and for the purposes specified in the subscribers' agreement;
(i) A copy of the subscribers' agreement;
(j) A statement that each of the original subscribers has in good faith applied for insurance of a kind proposed to be transacted, and that the insurer has received from each such subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than 6 months at an adequate rate theretofore filed with and approved by the office;
(k) A statement of the financial condition of the insurer, a schedule of its assets, and a statement that the surplus as required by s. 629.071 is on hand; and
(l) A copy of each policy, endorsement, and application form it then proposes to issue or use.
Such declaration shall be acknowledged by the attorney before an officer authorized to take acknowledgments.

629.091 Certificate of authority.—The certificate of authority of a reciprocal insurer shall be issued to its attorney in the name of the insurer.

629.101 Power of attorney.—
(1) The rights and powers of the attorney of a reciprocal insurer shall be as provided in the power of attorney given it by the subscribers.

(2) The power of attorney must set forth:
(a) The powers of the attorney;
(b) That the attorney is empowered to accept service of process on behalf of the insurer in actions against the insurer upon contracts exchanged;
(c) The general services to be performed by the attorney;
(d) The maximum amount to be deducted from advance premiums or deposits to be paid to the attorney and the general items of expense in addition to losses, to be paid by the insurer; and
(e) Except as to nonassessable policies, a provision for a contingent several liability of each subscriber in a specified amount, which amount shall be not less than 5 nor more than 10 times the premium or premium deposit stated in the policy.
(3) The power of attorney may:
(a) Provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder;
(b) Impose such restrictions upon the exercise of the power as are agreed upon by the subscribers;
(c) Provide for the exercise of any right reserved to the subscribers directly or through their advisory committee; and
(d) Contain other lawful provisions deemed advisable.
(4) The terms of any power of attorney or agreement collateral thereto shall be reasonable and equitable, and no such power or agreement shall be used or be effective in this state unless filed with the office.

629.121 Attorney's bond.—
(1) Concurrently with the filing of the declaration provided for in s. 629.081, the attorney of a domestic reciprocal insurer shall file with the office a bond in favor of this state for the benefit of all persons damaged as a result of breach by the attorney of the conditions of his or her bond as set forth in subsection (2). The bond shall be executed by the attorney and by an authorized corporate surety and shall be subject to the approval of the office.
(2) The bond shall be in the sum of $100,000, aggregate in form, the bond conditioned that the attorney will faithfully account for all moneys and other property of the insurer coming into his or her hands, and that he or she will not withdraw or appropriate to his or her own use from the funds of the insurer any moneys or property to which he or she is not entitled under the power of attorney.
(3) The bond shall provide that it is not subject to cancellation unless 30 days' advance notice in writing of cancellation is given both the attorney and the office.

629.131 Deposit in lieu of bond.—In lieu of the bond required under s. 629.121, the attorney may maintain on deposit with the department a like amount in value of securities qualified for deposit under s. 625.52 and subject to the same conditions as the bond.

629.181 Financial condition; method of determining.—In determining the financial condition of a reciprocal insurer, the office shall apply the following rules:
(1) The surplus deposits of subscribers shall be allowed as assets, except that any premium deposits delinquent for 90 days shall first be charged against such surplus deposit.
(2) An assessment levied upon subscribers, but not collected, shall not be allowed as an asset.
(3) The contingent liability of subscribers shall not be allowed as an asset.

Commissioner David Altmaier

Performance Evaluation and Leadership Assessment

Presented to:

The Financial Services Commission

June 14, 2017

Table of Contents

Performance Measures — April 1, 2016 – March 31, 2017

Accomplishments — First Year in Review

Moving Forward — Focus for the Coming Year

Performance Measures
April 1, 2016 – March 31, 2017

		First Year Average		3rd Quarter FY 2016-2017		2nd Quarter FY 2016-2017		1st Quarter FY 2016-2017		4th Quarter FY 2015-2016	
	Objective	**Result**	**Score**	**Result**	**Score**	**Result**	**Score**	**Result**	**Score**	**Result**	**Score**
1	Applications for a new certificate of authority and new types of insurance added to an existing certificate of authority within 90 days	*100.0%*	5	*100.0%*	5	*100.0%*	5	*100.0%*	5	*100.0%*	5
2	Life and health form and rate filing reviews completed within 45 days	*99.9%*	5	*99.8%*	5	*99.9%*	5	*100.0%*	5	*99.9%*	5
3	Property and casualty form filing reviews completed within 45 days	*99.7%*	5	*99.9%*	5	*100.0%*	5	*98.9%*	5	*100.0%*	5
4	Property and casualty rate filing reviews completed within 90 days	*99.4%*	5	*99.1%*	5	*98.9%*	5	*99.7%*	5	*100.0%*	5
5	Market conduct exams with violations in which the Office requires companies to remediate	*100.0%*	5	*100.0%*	5	*100.0%*	5	*100.0%*	5	*100.0%*	5
6	Financial exams of domestic insurers completed within 18 months of the "as of" exam date	*100.0%*	5	*100.0%*	5	-	*	-	*	*100.0%*	5
7	Life and health priority financial examinations of domestic insurers completed within 18 months of the "as of" exam date	*100.0%*	5	-	*	-	*	-	*	*100.0%*	5
8	Property and casualty priority financial examinations of domestic insurers completed within 18 months of the "as of" exam date	*100.0%*	5	*100.0%*	5	-	*	-	*	*100.0%*	5
9	Priority financial analyses completed within 60 days	*99.8%*	4.8	*100.0%*	5	*100.0%*	5	*99.0%*	4	*100.0%*	5
10	Non-priority financial analyses completed within 90 days	*99.8%*	4.3	*99.9%*	4	*99.6%*	4	*99.6%*	4	*100.0%*	5
	Overall Score		**4.87**		**4.89**		**4.86**		**4.71**		**5.00**

Note: Scoring is based on the scale adopted by the Financial Services Commission, with 1 being lowest and 5 being highest, and each measure of equal weight.

** Financial examinations are generally cyclical over long-periods of time and, while several are currently in progress, none were due in the first quarter or second quarter.*

First Year Accomplishments – Property & Casualty

Property Insurance

- Increased public awareness of AOB abuse and its negative impact on rates by highlighting rising trends in severity and frequency in water claims
- Licensed three new writers of homeowners insurance in Florida

Flood Insurance

- Helped foster the development of a private flood insurance market with an increase in private flood policies in force of roughly 1,000 in 2015 to more than 13,000 currently
- One new domestic flood insurance writer licensed

Business Development

- Licensed the first domestic captive insurer
- Facilitated the redomestication of three title insurers to Florida

Hurricane Activity

Two hurricanes impacted Florida in the second quarter of FY 2016-2017

- Completed successful roll-out of an Industry claims data call and monitored performance of property insurers
- Hurricane Hermine (as of March 3, 2017) had 19,699 total claims with estimated losses of more than $139 million
- Hurricane Matthew (as of March 3, 2017) had 119,345 total claims with estimated losses of more than $1.18 billion

First Year Accomplishments – Life & Health

Long-Term Care:

- Implemented an ambitious and innovative approach to help reduce the impact of rising long-term care premiums:
  - Extended rate guarantees
  - Multi-year phase-in of rate increases
  - Rate increase alternatives (e.g. flexible benefit periods and reduced inflation coverage)
  - Lapse protection

Life Insurer Solvency:

- Implemented SB 1308 (2014) which modernized life insurer solvency regulation and became effective on 1/1/2017

Medicare Supplement

- Modified rate review procedures and instituted a carrier outreach program to increase the number of carriers in the Medicare Supplement market

Focus for the Coming Year

- Identify opportunities to reduce pressures which limit consumer choice and the ability of the market to maintain relevance with changing consumer demands
  - Search for creative ways to assist our market participants in navigating significant shifts in market dynamics and a rapidly changing regulatory environment
  - Continue fostering a market environment which effectively and efficiently provides the product options Florida consumers need to best protect their families
- Remain dedicated to the importance of seniors in our marketplace
  - Recognize areas where the Office can continue to help ease rate impacts
  - Continue to protect insureds from unnecessary risk of loss of their investments

Questions?

Leadership Assessment

FLORIDA OFFICE OF
INSURANCE REGULATION

June 2017

David Altmaier, Insurance Commissioner

FINANCIAL SERVICES COMMISSION

RICK SCOTT
GOVERNOR

JEFF ATWATER
CHIEF FINANCIAL OFFICER

PAM BONDI
ATTORNEY GENERAL

ADAM PUTNAM
COMMISSIONER OF
AGRICULTURE

OFFICE OF INSURANCE REGULATION

DAVID ALTMAIER
COMMISSIONER

Dear Members of the Financial Services Commission,

I am pleased to present the annual leadership assessment for my first complete year as Commissioner of the Florida Office of Insurance Regulation (Office). The Office's commitment to promote a stable and competitive insurance market for all of Florida's consumers is stronger than ever. Florida's insurance market is currently the 10th largest in the world with a variety of insurance products serving the needs of more than twenty million Floridians.

The 292-member team at the Office remains steadfast in fostering an environment that allows reliable insurance products to be available to Florida consumers at affordable prices. Our staff works to fairly, efficiently, and professionally oversee Florida's insurance market, an effort that includes the review of the financial condition of more than 4,000 companies, thousands of form and rate filings, and the licensure of new entities. I am pleased our quantitative assessment score is reflective of the commitment of the Office.

The Office also addressed several significant developments in the insurance market in Florida. Specifically, several Supreme Court decisions have adversely impacted Florida's Workers' Compensation market, continued rising loss trends in the property market associated with water losses, the first land falling hurricane in over a decade, and continued uncertainty in the health care market. Throughout, we have strived to develop solutions that are consumer-centric, while promoting choice and supporting changing market demands.

Serving the citizens of the State of Florida has been an honor and, while I take pride in what we have accomplished during my first year, I firmly believe that all organizations and individuals have room for improvement. Completing this evaluation and responding to the leadership assessment questions has been extraordinarily useful in identifying areas that need our continued focus. I look forward to working with each of you in the days and months ahead to promote insurance coverage that is reliable, available and affordable.

Sincerely,

David Altmaier

David Altmaier

Leadership Assessment Questions and Answers

1. **How do you define success in your agency?**

   Success in our agency is defined by an insurance market that allows ***reliable*** insurance products to be ***available*** to Florida consumers at ***affordable*** prices.

   First and foremost, insurance consumers are buying what amounts to a promise from entities regulated by the Office: a promise that during a time of loss, the insurance company will indemnify the insured for their covered loss in a timely and professional manner. As the Insurance Commissioner, I have an expectation those promises are, and will continue to be, fulfilled. Many of the Office's operational functions are geared toward focusing on these efforts and providing stability within the marketplace.

   Second, insurance consumers benefit from the ability to choose from a range of options on how best to insure themselves from unexpected loss. The availability of a wide range of products across various insurance lines places consumers in the best position to protect their families and businesses. Furthermore, competitive market forces will work to bring product innovation and competitive pricing to the market, which serves in the long run to benefit Florida consumers.

   Finally, and perhaps most challenging of all, insurance consumers deserve products that are priced according to their underlying risk, and not unduly influenced in an adverse way by extenuating factors. A reasonable measure of success for the Office is the ability to highlight and find solutions addressing market conditions that serve as unnecessary cost drivers for consumers.

2. **What services does your agency provide that are most undervalued?**

   When a consumer receives a new personal lines insurance policy in their mailbox, they will likely immediately take note of three important items: the cost, the name of the insurance company they have selected, and the terms of the new insurance policy. The behind-the-scenes effort to painstakingly review each of those items before it ever arrives in their mailbox is significant. Before the insurer listed on the policy is admitted to write business in Florida, they must undergo a process to determine if their business plan, management team, and financial resources are appropriate. Thereafter, the company continues to be reviewed on a periodic basis, with an emphasis on ensuring there are no material deviations from their business plan, the management team continues to serve the best interests of their consumers, and their financial condition is suitable in meeting their policyholder obligations. The premium charged is reviewed by Office actuaries to determine that the rate is not excessive, inadequate, or unfairly discriminatory.

Additionally, the policy provisions are reviewed in detail by the Office's product review team to assess whether the terms of the policy are fair and reasonable. Often, after receiving their policy in the mail, consumers may file it away with other important documentation and not review it again until there is a loss or it is time to renew coverage. However, the efforts at our agency persist. Not only do we continue monitoring the financial condition of each insurer operating within our jurisdiction, we also review market activity and consumer complaints to determine that companies are acting fairly and professionally.

Understandably, the breadth and reach of these efforts can go unnoticed by the public; however, these are responsibilities we continue to take very seriously.

3. What outcomes do you plan to accomplish as agency head as it relates to your short and long term priorities?

The three pillars to a consumer-centric and robust insurance marketplace, and therefore, keys to our success, are the reliability, availability, and affordability of insurance products. As a result, the outcomes we hope to achieve in the short-term and long-term relate to identifying conditions in our marketplace that prevent any of those three principles from being met. The following items are an example of what we would like to address in the short-term:

- Mitigating consumers against unnecessary rate impacts arising from Assignment of Benefits (AOB) associated litigation;
- Stabilizing the individual and group health insurance markets sufficiently enough that carriers return to our market and uncertainty surrounding consumer rates are alleviated;
- Advocating for policies that encourage a more vibrant private flood insurance market;
- Examining ways to mitigate rising automobile insurance premiums; and
- Continuing to advance innovative policies to diminish the substantial instability and rate inadequacy in our long-term care insurance market;

Each of these initiatives were selected because they impact a large number of Floridians and each of the respective markets face challenges from the standpoint of the reliability, availability, or affordability of insurance products.

a. Do your resources align with your priorities in order to achieve these outcomes?

The Office currently has sufficient resources to continue its diligent oversight and regulation of insurers and other risk-bearing entities. However, as with any other state agency, technological advances and staffing needs will require additional requests for resources to allow us to achieve and maintain operational efficiencies as we address our priorities.

b. How do your priorities align with the agency's legislative proposals and legislative budget request?

Achieving legislative reform to address the rising costs associated with AOB related litigation has been our number one legislative priority, and will continue to be until a remedy is put into place that will lessen the burden this is placing on Florida homeowners. Currently, the remaining legislative priorities can generally be achieved through administrative process or advocacy.

The Office's legislative budget request is many times directly influenced by the changing conditions experienced within the marketplace and that affect our regulatory oversight of insurance companies and risk-bearing entities. As we adapt to these changes and streamline internal processes to meet these demands, our legislative budget request is crafted to match the changing needs of our agency as it may relate to funding, staffing, administrative functions, and operational processes.

c. What are the drivers and resistors that will help or hinder you from meeting these priorities?

The fact that many consumers are either unable to obtain insurance or are experiencing significant rate increases for the products they do have serve as drivers to meet these priorities. Additionally, there appears to be a consensus amongst stakeholders on several of our priorities, which should also serve as a driver for success. However, resistors include certain stakeholders that are averse to our ideas for reform and the issue of addressing markets overseen in large part by federal law.

d. How does the agency organizational structure support these priorities?

The Office's organizational structure is designed to work cohesively to support our priorities. Each business unit has defined technical expertise and works collaboratively with other business units in the licensing, form and rate review, and solvency monitoring processes. This structure plays a primary role in our ability to detect trends and conditions that impact the insurance marketplace, while also effectively providing stability to allow consumers access to products that are available, reliable, and affordable.

e. How are you measuring progress toward outcomes?

The Office uses a variety of technical and analytical resources and information to measure the progress of outcomes. These include:

- Rate impacts on consumers arising from AOB and associated litigation is measured by monitoring the rate activity of Florida's property writers as well as

the number of companies writing new and renewal business in certain areas of the state.

- Stability in the individual and group health insurance can be measured by the number of health carriers offering on-exchange plans in Florida counties, as well as rate activity associated with such plans.
- Cultivation of a more vibrant private flood insurance market can be measured by tracking the number of flood policies issued by private carriers and the number of private carriers offering flood insurance in Florida.
- Rising automobile insurance premiums can be measured by statewide rate activity.
- The advancement of innovative products to address instability and rate inadequacy in the long-term care insurance market can be measured by tracking rate activity and the number of companies continuing to offer products.

4. What program areas of your agency face challenges in achieving desired outcomes?

The financial regulation of insurance companies is becoming more complex as insurance groups increase in sophistication and expand globally. The issues that represent prospective risks become more wide-ranging and include a larger number of stakeholders. For these reasons, it is imperative our financial solvency units are staffed with individuals that are experienced, possess the technical backgrounds and tools necessary to stay apprised of market trends, and capable of identifying potentially troublesome future trends. However, our financial solvency units have historically faced the most significant level of staff turnover, making it difficult to cultivate this level of experience and background.

a. What major issues are contributing to each area's weaknesses?

The primary issue contributing to this weakness is the uncompetitive nature of the salaries offered to employees in these business units when compared with the salaries they could earn if they worked in the private sector or other state agencies.

b. What internal or external threats exist?

Internally, we face two primary threats; the ability to modernize and the ability to retain talent. The Office needs to keep pace as the insurance world and the general marketplace, which drives the need for expanding product portfolios, continues to innovate. This requires the retention of experienced and increasingly talented and trained personnel, as well as, the provision of the tools necessary to effectively leverage those talents and skills moving forward.

Overcoming these internal obstacles require resources, innovative thinking, and an effective balancing of short-run constraints and long-run vision. While we are

continually looking at ways to meet the latter two requirements, it is availability and flexibility of resources where we encounter challenges. Investments in people and modernization efforts enable the Office to be more nimble and efficient as well as enabling us to stem long-run increases from a resource perspective.

The Office also faces external threats such as the outcome of legislation beyond our control; one example being the future of the Affordable Care Act. Uncertainty can create significant challenges in the development of a healthy and competitive market, and the inability for market participants to assess the likelihood of future conditions reduces opportunities to expand options for consumers in our state. We consistently attempt to monitor these threats and find ways to help navigate our insurance market through these challenges.

c. What are the strategies you have planned to address these issues?

During the most recent legislative session, we designed a legislative budget request (LBR) specifically addressing this issue. While we were not successful in achieving the LBR as originally presented, we obtained some flexibility in attracting and retaining qualified employees. Additionally, we are taking steps to consolidate and modernize our processes to appropriately apply capital to labor with the objective of increasing output and the capacity to pivot as the marketplace changes.

d. What major changes need to occur to achieve the desired outcome?

We will continue to strive to make the Office an attractive place to work, but the primary motivating factor for employees to either leave the Office or never join in the first place will remain the disparity in salary. We will continue to pursue solutions to this challenging issue when we discover employees who add value to our organization.

5. What do you view as the greatest risk in the next fiscal or calendar year?

We have identified two primary risks with potentially significant impacts to the insurance marketplace.

The greatest risk to our property insurance market has, and will continue to be, the risk of a catastrophic event. While our property insurance market has made strides in the past several years towards shoring up capital and surplus positions, there is always a level of uncertainty associated with natural catastrophes that must be considered on an annual basis.

Our health insurance market also faces significant uncertainty with the pending fate of the ACA, but the most immediate and potentially detrimental risk is the possibility Cost Sharing Reductions (CSR) will not be funded. CSRs are monies owed to health plans under the ACA which are currently the subject of a pending lawsuit. Unfunded, this would represent billions

of dollars of losses to the plans remaining in Florida's market. To offset the loss of the CSRs going forward may result in substantial rate increases for Florida consumers.

a. How do you plan to mitigate the risk and address this issue?

Our efforts to mitigate the risk of market turmoil are year-round. We monitor the exposure, surplus, profitability and rating plans of all insurers offering personal property insurance in Florida. Perhaps our most important mitigation tool is the Annual Reinsurance Data Call, a process to review the reinsurance plans put in place by insurers to offset the losses caused by catastrophic events.

Mitigating unfunded CSRs will consist of a thorough review of plans' capital conditions and the rating plans they file. Additionally, the speed of our regulatory response will be important when a decision is made regarding CSRs.

6. What current agency responsibilities do you consider unnecessary or obsolete, or would be best accomplished by another agency?

There are a few products the Office regulates which are not covered by guaranty funds, are optional coverages, and the state's regulation achieves a limited amount of consumer protection. Some of these products could require a disclaimer that they are not subject to oversight and be marketed without regulation by the state.

7. Stakeholders:

a. Identify your stakeholder groups and opportunities for stakeholders to interact/provide input to your agency.

Our stakeholders can be largely grouped into three main categories: insurers, insurance consumers, and a variety of other parties with a vested interest in what occurs in the insurance marketplace. The latter group includes, but is not limited to, agents, adjusters, doctors, hospitals, repair shops, and other vendors that have relationships or conduct business within the broader insurance market.

b. What are the top issues communicated by stakeholders, and what plans are in place to address these issues?

Given the volume of stakeholders, the issues communicated to the Office can be extensive. However, they can generally be broken down as:

1. **Market Stability**. We often hear from all three groups of stakeholders about the need to avoid policies or procedures that would be viewed as disruptive. This

includes conversations related to policies or procedures in place or under consideration by the Office, other agencies, or deliberative bodies.

2. **Speed to Market**. We often hear, primarily from insurer groups, about the need to effectively balance our duties to review and approve rates and forms with the ability for insurers to get new and innovative products to market quickly.
3. **Treatment of Consumers/Interested Parties**. Finally, we hear from insured's, interested parties, and their representatives about ways to improve the consumer experience. These issues can range from premium increases and the readability of policy forms to the ability of groups such as providers and vendors to receive compensation from insurers, and the adequacy of that compensation.

c. How do you assess whether or not your stakeholder needs are met?

Given the broad range of stakeholders and the difference in their policy positions, balancing their needs becomes one of the most challenging aspects of our role. It will never be possible to achieve a 100% satisfaction rate; however, our number one goal becomes ensuring that all stakeholders have the opportunity to add their perspective throughout the decision-making process. We accomplish this responsibility by being transparent and open in how we perform the many functions of the Office.

A good example of the type of decisions made by the Office that comes with an extensive range of stakeholder positions is a rate filing made by a hypothetical insurer. Consumers could voice concerns that rate increases are unwarranted and unaffordable, and attempt to sway the Office to approve a lesser amount or nothing at all. The insurer will raise concerns that not approving an appropriate rate could hinder their ability to pay claims or to continue to actively participate in our market. The decision ultimately made by the Office may leave one, or both, of these two stakeholder groups unsatisfied with the outcome. Therefore, it is the goal of the Office, when dealing with stakeholders, to facilitate an environment in which each stakeholder is afforded the opportunity to present their viewpoints and perspectives. Finally, when a decision is rendered on an issue, it is as informed as possible by the input we have received throughout the process.

FLORIDA OFFICE OF
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