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

June 26, 2012

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

Contact: **Ashlee Falco**
(850-413-5069)

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

ITEM	SUBJECT	RECOMMENDATION

1. Minutes of the Financial Services Commission for September 20, 2011; November 1, 2011; and December 6, 2011.

FOR APPROVAL

2. Request for Approval for Publication of Proposed Amendments to Rules 69O-137.001, Annual and Quarterly Reporting Requirements and 69O-138.001, NAIC Financial Condition Examiners Handbook Adopted

   These rules are being amended to adopt the current versions of the NAIC instructions, manuals and Financial Condition Examiners Handbook. The adoption of these rules will put Florida in compliance with national standards, thereby reducing regulatory costs to business.

(ATTACHMENT 2) **APPROVAL FOR PUBLICATION**

3. Request for Approval for Publication of Proposed Amendments to Rule 69O-149.003, Rate Filing Procedures

   Pursuant to Section 627.410(6)(a), F.S., health insurers seeking to issue or renew health insurance policy forms in the State of Florida must submit documentation to the Office demonstrating that the proposed policy's premium rates are reasonable in relation to the benefits provided. Rule 69O-149.003 provides insurers with instructions on how to make these filings.

   Rule 69O-149.003(5) allows insurers without fully credible data to make streamlined rate increase filings with the Office that are simpler in format and content than the full filing format defined in Rule 69O-149.003(2). Insurers who qualify and elect to file streamlined rate increase filings with the Office are limited to rate increases equal to the maximum annual medical trend for medical expense coverage or the maximum annual medical trend for Medicare Supplement coverage. The current version of Rule 69O-149.003(6) includes

tables which display the applicable maximum annual medical trend. The proposed rule amendment simply makes these tables available on the Office's website instead of in the rule itself. The Office will update the tables as needed.

Rule 69O-149.003(5)(a) defines the qualifications insurers must meet to make streamlined rate increase filings. These proposed amendments to 69O-149.003(5)(a) provide for streamlined rate filings for Medicare Supplement providers with fewer than 1,000 policyholders nationwide rather than to 1,000 policyholders in Florida.

(ATTACHMENT 3) **APPROVAL FOR PUBLICATION**

4. Request for Approval for Publication of Proposed Amendments to Rule 69O-149.022, Forms Adopted

   The purpose of this rule is to update and edit the contents of the Universal Standardized Data Letter (UDL) form and instructions used by Life and Health insurers to make electronic form filings via the Office's I-File system. The proposed revisions simplify the reporting entries to reflect recent technological upgrades.

(ATTACHMENT 4) **APPROVAL FOR PUBLICATION**

5. Request for Approval for Publication of Notice to Repeal Rule 69O-164.030, Application of Rule 69O-164.020 to Various Product Designs

   The Office of Insurance Regulation (Office) recently conducted a comprehensive review of all agency rules to determine whether some rules should be modified or eliminated. As a result, it has been determined that Rule 69O-164.030 is unnecessary and should be repealed. This rule concerns reserving approaches for guarantees established by universal life insurance policies. The repeal of this rule will make the Florida Insurance Code more consistent with the National Association of Insurance Commissioners' (NAIC) model laws and rules, thereby reducing the regulatory cost of doing business in Florida.

(ATTACHMENT 5) **APPROVAL FOR PUBLICATION**

6. Request for Approval for Publication of Notice to Repeal Rules:

   69O-198.003, License Required;
   69O-200.013, Rate Filings;
   69O-170.012, Sinkhole Insurance;
   69O-191.072, Reinsurance (excess Loss Insurance)

   These rules are being repealed either because the statutes adopted to implement them have been repealed (making them obsolete) or they restate language already contained in the Florida Insurance Code.

(ATTACHMENT 6) **APPROVAL FOR PUBLICATION**

7. Request for Approval for Publication of Notice to Repeal Rule 69O-143.045, Definitions

   Rule 69O-143.045 was originally promulgated in the early 1970s. The rule defines a list of insurance terms. Many of the terms defined in the rule are inconsistent with current portions of the Florida Insurance Code. As a result of these inconsistencies, the Office requests the rule be repealed.

   (ATTACHMENT 7) **APPROVAL FOR PUBLICATION**

8. Request for Approval for Publication of Notice to Repeal Rule 69O-142.011, Insurer Conduct Penalty Guidelines

   This rule establishes guidelines for the assessment of administrative fines concerning certain violations of the Florida Insurance Code.

   This rule became effective on November 6, 1994. Since that time, many of the fines prescribed by the rule have become antiquated. Section 624.4211, F.S., contains guidelines for the assessment of administrative fines. As a result, this rule is unnecessary and should be repealed.

   (ATTACHMENT 8) **APPROVAL FOR PUBLICATION**

9. Request for Approval for Adoption of Proposed Amendments to Rules 69O-200.004, 005,.006,.009,.014,.015, Auto Manufacturer Warranty Rules

   In Sections 634.011(7) and 634.041(12), F.S., the Legislature created a new category of Motor Vehicle Service Agreement Companies: "Motor Vehicle Manufacturers." The purpose of the legislation was to *eliminate certain regulatory requirements* for these large corporations, under certain circumstances. These amendments address the legislative mandate to modify these rules and forms to incorporate this new category.

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

10. Request for Approval to Repeal Rule 69O-170 Part V; Arbitration Rules

    Section 627.062(6), F.S., originally granted insurers the right to arbitrate rate filing disputes with the Office. The Financial Services Commission adopted the above referenced rules regarding arbitration of rate filings. This section of law has subsequently been amended to remove the provision for arbitration. Consequently, the Office requests the rules associated with it be repealed.

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

T H E C A B I N E T

S T A T E O F F L O R I D A

Representing:

BOARD OF TRUSTEES OF THE INTERNAL IMPROVEMENT TRUST FUND
ADMINISTRATION COMMISSION
FLORIDA LAND AND WATER ADJUDICATORY COMMISSION
DIVISION OF BOND FINANCE
FINANCIAL SERVICES COMMISSION, FINANCIAL REGULATION
FINANCIAL SERVICES COMMISSION, INSURANCE REGULATION
DEPARTMENT OF REVENUE
DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES

The above agencies came to be heard before THE FLORIDA CABINET, the Honorable Governor Scott presiding, in the Cabinet Meeting Room, LL-03, The Capitol, Tallahassee, Florida, on Tuesday, September 20, 2011, commencing at approximately 9:09 a.m.

Reported by:

MARY ALLEN NEEL
Registered Professional Reporter
Florida Professional Reporter
Notary Public

ACCURATE STENOTYPE REPORTERS, INC.
2894 REMINGTON GREEN LANE
TALLAHASSEE, FLORIDA 32308
850.878.2221

GOVERNOR SCOTT: All right. The next agenda is the Financial Services Commission, Office of Insurance Regulation, presented by Kevin McCarty.

MR. McCARTY: Good morning, Governor and members of the Commission.

Agenda Item Number 1 is adoption of the minutes for August 2nd and August 16th.

GOVERNOR SCOTT: Is there a motion to approve Item 1?

ATTORNEY GENERAL BONDI: Move to approve.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Moved and seconded. Show Item 1 approved without objection.

MR. McCARTY: Agenda Item Number 2 involves three rule modifications that have been presented to you before. We're here today for final adoption.

The first one has to do with the adoption of changes to the actuarial memorandum as it relates to reserving. The second agenda item, the second item in that rule set is changes in the mortality tables, and lastly, changes in reserve analysis.

The culmination of these rules is really part of our modernization effort to move away from one

size fits all. Formerly, everyone had to use the same mortality table and the same actuarial memorandum.

As we evolved in business, we have a different complex set of products that are out there, and this more closely aligns the reserves to reflect the risk of an individual company so there's more flexibility built in instead of one size fits all. This is consistent with national standards as well as international standards.

GOVERNOR SCOTT: Any questions? Okay. Is there a motion to approve Item 2?

ATTORNEY GENERAL BONDI: Move to approve.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Moved and seconded. Item 2 is approved without objection.

MR. McCARTY: Agenda Item Number 3 is a request for approval for adoption of changes to the Financial Condition Examiners Book. Florida law requires the Office of Insurance Regulation to conduct financial examinations. This merely adopts the latest version of the National Association of Insurance Commissioners' exam handbook.

GOVERNOR SCOTT: Is there a motion to approve

Item 3?

CFO ATWATER: So moved.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Moved and seconded. Show Item 3 is approved without objection.

MR. McCARTY: Agenda Item Number 4 is appointment of Rocky Rodriguez to the Workers' Comp JUA.

GOVERNOR SCOTT: Is there a motion to approve Item 4?

COMMISSIONER PUTNAM: So moved. That's a good step.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Strong second.

GOVERNOR SCOTT: Moved and seconded. Item 4 is approved without objection.

MR. McCARTY: Agenda Item Number 5, Governor, we wish to withdraw that from consideration at this time.

GOVERNOR SCOTT: Is there a motion to withdraw Item 5?

CFO ATWATER: So moved.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Moved and seconded. Item 5 is withdrawn without objection.

MR. McCARTY: Thank you very much. Appreciate it.

CFO ATWATER: Governor, could I just make a quick comment? I just wanted to express gratitude for the manner in which Commissioner McCarty so quickly addressed concerns that arose from the Citizens rate filing, and particularly that there is a need that both businesses and consumers have fast responses and can remove uncertainty, that you took the inconvenience of going to Tampa so the citizens of Florida could participate and watch how their government works and how the process works, and the quality of what you all ultimately put together to take into account the work of the Legislature to try to remove the fraud and the activity that has been so harmful in the marketplace and get down to giving consumers the right product at the right price and the right value.

And I know it's no perfect science, but I just think the speed with which you did it and the inconvenience which you put your own staff and team through, I know you must be very proud of the speed

and the quality that your team came up with. So thank you.

MR. McCARTY: Thank you, and I do thank my colleagues for the long hours working over the weekend and late last night to complete within the statutory framework. I also want to thank the Office of Consumer Advocate for their input at the hearing and your fraud officers, as usual. Thank you for their service.

GOVERNOR SCOTT: Thank you very much.

T H E C A B I N E T

S T A T E O F F L O R I D A

Representing:

STATE BOARD OF ADMINISTRATION

FINANCIAL SERVICES COMMISSION, OFFICE OF INSURANCE REGULATION

FINANCIAL SERVICES COMMISSION, PRESENTATION

BOARD OF TRUSTEES, INTERNAL IMPROVEMENT TRUST FUND

The above agencies came to be heard before THE FLORIDA CABINET, Honorable Governor Scott presiding, in the Cabinet Meeting Room, LL-03, The Capitol, Tallahassee, Florida, on Tuesday, November 1, 2011, commencing at 9:05 a.m.

Reported by:
CAROLYN L. RANKINE
Registered Professional Reporter
Notary Public

ACCURATE STENOTYPE REPORTERS, INC.
2894 REMINGTON GREEN LANE
TALLAHASSEE, FLORIDA 32308
850.878.2221

GOVERNOR SCOTT: The next agenda is the Florida Financial Services Commission, Office of Insurance Regulation presented by Kevin McCarty. Good morning, Kevin.

MR. McCARTY: Good morning, Governor and members of the Commission. *Florida Statutes* requires the Financial Services Commission to contract every other year for an independent actuarial analysis to be done of any rating organization licensed to make rate filings for Florida.

The NCCI, National Council on Compensation Insurance, is responsible for collecting statistical information on behalf of Florida's insurance companies, and by contract we're supposed to provide a report to the Senate President and Speaker of the House by February.

In October the OIR, with the assistance of the Department of Financial Services, issued and submitted a statement of work and a request for quotes for three vendors, and in order to meet our statutory requirement it is recommended that the office, on behalf of the Commission, accept the technical proposal

received by Exam Resources.

GOVERNOR SCOTT: All right. Have any questions? No.

All right. Is there a motion to approve Item 1?

ATTORNEY GENERAL BONDI: Move to approve.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Moved and seconded. Item 1 is approved without objection. Thank you, Kevin.

MR. McCARTY: Thank you, Governor.

GOVERNOR SCOTT: CFO Atwater, would you please introduce the next item?

And thank you. I was hoping, Commissioner McCarty, will you be able to stay through the next couple of presentations? I don't know if your schedule is going to permit you to.

MR. McCARTY: That would be great. Thank you.

GOVERNOR SCOTT: Thank you.

CFO ATWATER: Governor, I think all of us, and I know that each member of the Cabinet has spoken to this matter, as have many legislators, that we have to address what we know in Florida as personal injury protection coverage this legislative session, that it began in the early '70s as an extraordinarily valuable instrument in ensuring one's ability to have -- have quick access to health care needs if they were involved in an accident no matter who was involved, the idea, of course, being a low litigation type of tool for us in Florida. And for many, many years it has proved to be just that effective.

And we're in a period of time now where we

know that many are challenged without any type of health care. This is provided -- and not -- that wouldn't be the purpose of establishing a PIP system, a personal injury protection, went in law by itself, but we know that today it is providing that comfort as well to a family knowing that all else, if, in fact, an injury occurs in this form, in an accident in an automobile, they at least have that kind of coverage.

And to our hospitals it has been extremely valuable, again, to be able to provide that service and to have -- and to be made whole from that type of care that we're providing.

It is -- it is abundantly clear from all the efforts that I believe have been made over the last year to look closely at this that this -- that our personal injury protection laws need bold and significant change, that fraud has found its way so deeply into the system that the industry questions whether or not it should participate here, and it has removed capital from certain markets. Players who honestly provide services find themselves caught up in everything being questioned

because of the amount of fraud that exists.

But at the heart of it all, at the center of it all, if our focus just stayed on consumers, where it should always be, we know that change must occur because the honest citizen -- and you're going to see in this report today -- the honest Floridian trying to get by is the one that is suffering from this system, it is required by law that they have it if they're going to have access to a vehicle, and they are getting taken to the cleaners in the fraud that is now built into the premium. We're going to see that today.

Now, specifically to the presentation itself. I asked our Consumer Advocate, Robin Westcott, who -- if you haven't had a chance to get to know Robin, there is no more enthusiastic, energetic, tireless worker in this Capitol -- and she has gone after this -- I asked if she would do something rather extraordinary: could she bring together all the constituency groups that provide or are associated with personal injury protection. That would be, of course, the carriers themselves, the insurance industry; that would

be the providers, whether it be chiropractic care, whether that be health care clinic, that would be MRIs, that would be the M.D.s themselves, whether that be the hospitals themselves; to bring together consumer advocates as well; to bring together those who are involved in litigation itself, those who would represent injured Floridians.

They all participated over a number of gatherings to work as quickly as they could to inform us of some of the information that is before us today. It would not surprise you for me to add regrettably they could find no consensus. They are -- they stand in their spot, they're holding to the traditional place that they have, they could not suggest a common ground on where to go forward. That wouldn't surprise us though.

However, I think when you look at the evidence that you're going to see, there are some clear places we must go, I'll leave that to our Consumer Advocate to share with all of us.

And in the end, in the end, if we can make some of these -- we have to make these

changes. We make these changes in the end, what will be incumbent upon the industry itself would be to rapidly and aggressively reduce the rates that they are charging to Floridians and apply the appropriate cost to a legitimate system so that the care can be provided as quickly as possible without litigation, which was the -- with minimal litigation, which was the intent of the original -- of the original product.

So, Governor, I would like to welcome up our Consumer Advocate, Robin Westcott, to walk us through a series of PowerPoint presentations. She will be providing to you, Governor, and to the Cabinet Members in the next few days a written report that backs up the PowerPoints you're going to see today. Thank you, Governor.

GOVERNOR SCOTT: Good morning.

MS. WESTCOTT: Good morning. Thank you for the opportunity to speak before you this morning. I hope that this will add value to the discussion about PIP.

In 1971 Florida enacted the no-fault law here, the Florida Vehicle No-Fault Law. The

intent of the no-fault law was to provide a minimum level of insurance benefits for minor insurance injuries sustained in a motor vehicle crash without regard to fault. And the benefit of PIP, or personal injury protection coverage, was to provide prompt payment for economic losses without navigating the tort system. In other words, pay claims quickly, pay people quickly, and avoid litigation.

In 1979 the benefit was increased to $10,000, and throughout the life span of personal injury protection in our state, we have seen a battle to keep this coverage free of fraud and abuse. As a result, anti-fraud provisions were added throughout 2001 and 2003.

In 2007 PIP was allowed to sunset in Florida law. When it was reenacted with some of the emphasis being for the support of the public hospitals and facilities of our state to have a funding source that is immediate and available, it was done so with a fee schedule.

Florida is now one of the only 10 states that has a no-fault system. Most states maintain a tort system of liability, and

at-fault drivers are liable for economic and noneconomic damages they inflict on other people. In most cases that coverage would be the bodily injury protection coverage.

Bodily injury is sometimes required in other states or mandated and that would be what would cover you in the event -- or cover injuries to other persons that are sustained in an accident. If no other form of auto insurance is mandated, then you would see that the uninsured motorist coverage would become a very paramount importance in the coverage that you purchase as a consumer insured.

As revealed in the OIR data culled, the number of claims filed under PIP has increased since 2008. The total number of claims opened in 2010 increased by 28 percent, and the total number of closed claims rose by 40 percent.

As Commissioner McCarty stated in his August presentation, there's been no associated rise in drivers in our state. We still hold steady at about 16 million licensed drivers in our state. In addition, there's actually been a decrease in the frequency of auto crashes since 2005. So for every 100 licensed drivers,

there are about one and a half crashes.

The no-fault system in Florida has seen periods of years -- throughout the years of susceptibility to fraud and abuse with a resulting rise in claims, but at no period of time prior have we seen this system be so pushed to the point with such dramatic increases in losses paid for this coverage which, in turn, result in nothing but rate increases for our Florida consumers.

The five major carriers in our state over the past several years have had up to as much as 72 percent increases in their rate.

It's important at this point to look at what are the losses or how the loss is effected in the insurance company setting. And according to 2010 financial statements submitted by insurers to the National Association of Insurance Commissioners which are subject to audit and filed underneath a sworn statement as to their accuracy and veracity, Florida's results for PIP shows direct losses have increased from approximately 1.5 billion in 2007-2008 to approximately 2.3 billion in 2010.

In addition, direct variable costs, which would be the losses and costs associated with administering the policy and any claims now exceed $2.7 billion. The insurers only collected 2.3 billion in premium for this coverage.

This rise in claims with no more drivers and actually fewer accidents leads you to assume that most, if not all, of the additional 900 million is a fraud and abuse tax that consumers will pay in higher rates.

Simply put, for every dollar of premium that is paid for PIP, insurers are paying out more than a dollar 15, and this is not a sustainable business model. All of this translates into increases in premium for the consumer.

There has been questions throughout the meetings of the work group as to whether there's actually any real threat, or any real damage sustained by our consumers in our state. And as the consumer advocate, I would like to show you the next couple of slides that really indicate what this means for an average Florida family in certain sections of our

state.

And please -- oops, what did I do?

CFO ATWATER: Governor, could I just ask -- I just want to be -- I think we're all very clearly with you, but just so there's no question here: What the Advocate just showed us is there's fewer cars for accidents per 100 cars, but there's also -- it's a pure decline in the number of accidents as well. That's not a ratio that anything was being hidden. There are fewer accidents -- pure number -- fewer accidents occurring every year in Florida.

And in showing the actual amount of claims being paid, those are audited numbers, this is not something that was just provided to this work group to disguise anything. They had to -- just as anybody would have had to provide an unqualified audited opinion, this is audited numbers that are provided. And what the follow up is, is that no one's disputing that those losses that are audited represent 100 percent of the premium that comes in, the direct loss.

So I would assume -- and maybe Commissioner McCarty might -- he spoke to it a

couple of months ago, regrettably, to keep these companies here, you have to make their business model work. And if we have a system that provides this much fraud where every dollar collected is a dollar lost, the Commissioner has no choice but to keep increasing the premiums so that they can stay here in Florida.

So I just don't want -- all the evidence you've seen today is audited numbers provided independently to us from audited credentialed players and not something that the company could just give us to take their word for it. Thank you.

MS. WESTCOTT: Thank you. I'd also point out, as CFO Atwater had said, that there is a pressure from the insurance company's perspective of whether they can stay and maintain this business model. Well, you know, it might be one of those situations where you say, well, that's okay, but this is a mandated coverage.

So any consumer that's coming to them for an insurance policy where they would want to sell them another type of coverage like the DI,

or like uninsured motorist, or collision, or any other that you would find in a standard automobile policy, if they can't sell them that basic PIP coverage, chances are you're going to go somewhere else to find the mandated coverage that you need.

So it is an all or one proposition for some of the companies and it is a business model. As a former solvency regulator, I -- I was -- you know, that was always one of the things: Can you cover your losses in the event that you have them. And the natural response is to raise rates.

GOVERNOR SCOTT: So why have these other states gone away from PIP? Because you said there's only 10 states left?

MS. WESTCOTT: There are. Looking at some of the information that was provided -- especially the State of Colorado, which is the most recent state to move away from a PIP system -- they had many of the same types of concerns that we have, the -- a rise in costs associated with delivery of the product such that they had pressures on the premiums, on consumers, and an overall cost prospective of

losses that were exceeding what -- you know, however, their benefit I think was greater than our benefit which is $10,000.

So for us to put that in perspective, I think that's, okay, we have a $10,000 benefit that we are putting so much money and effort and time into trying to cost contain compared to other states whose limits are far greater than ours.

I think that they probably came to the conclusion at some point that this is not a sustainable business model for anyone, it's costing consumers too much and we're spending too much time trying to police it. And therefore they put that model and shifted into a tort system to provide -- to try to avoid some of those costs.

GOVERNOR SCOTT: Thank you.

MS. WESTCOTT: Certainly. I want to continue with some of the -- just the direct effect and how this really does harm our Florida families. We're looking at slides from two companies, State Farm Mutual and Direct General, which are the largest standard and nonstandard writers for our state,

respectively. And these are -- this information was submitted as part of a rate filing which is also submitted with an affidavit as to veracity and reviewed by the Office of Insurance Regulation.

But for Florida families starting in the central Tampa area, the top line, two thou -- that's per car -- $2,000 for the average family where you have two adults and two driving-age children. Well, $2,000 in central Tampa for these two companies. And then if you look over at Hialeah on the third and fourth slides, you're looking at over almost $3,000 for a family.

You're looking at increases for a retired couple that are more than double. These are people that are on fixed incomes. And view these slides in the context that the average median income in these areas is $40,000 for a household, and there's better than 10 percent unemployment for these areas. So you're looking at $3,000 out of someone's budget for a $10,000 benefit.

GOVERNOR SCOTT: After tax. You're saying it's after tax, right?

MS. WESTCOTT: Yes, sir.

GOVERNOR SCOTT: Yeah. So that's 40,000 pretax.

CFO ATWATER: Yeah. Right.

MS. WESTCOTT: Yes, sir. One of the first directives after being appointed as the Insurance Consumer Advocate was to look at the PIP system --

GOVERNOR SCOTT: Would you go back a bit? Let's look at something real quick.

MS. WESTCOTT: Yes, sir.

GOVERNOR SCOTT: Go back to your Hialeah slide for Direct General.

MS. WESTCOTT: Yes, sir.

GOVERNOR SCOTT: Look at 2008. I mean, look at these numbers. 2008, 490 to 2,998 in one year.

MS. WESTCOTT: Yes, sir.

GOVERNOR SCOTT: What percentage of the state is uninsured right now, 15?

MS. WESTCOTT: I'm sorry?

GOVERNOR SCOTT: Do you know, Kevin?

MS. WESTCOTT: Uninsured?

GOVERNOR SCOTT: Yeah.

MS. WESTCOTT: Twenty-one percent have no

health insurance.

GOVERNOR SCOTT: How about no auto insurance?

MS. WESTCOTT: That's debatable. There's information from the Department of Highway Safety, Motor Vehicles that actually tracks the people that are stopped or pulled over, and insurance companies have to report as to who's been canceled for insurance. Their number suggests it's somewhere around one to two percent of drivers.

However, information for -- from some other sources, I believe that the Insurance Information Institute or Insurance Research Council have that number more at 24 percent. That's kind of more of a bodily injury number.

Highway Safety and Motor Vehicles kind of concedes that they don't believe that's accurate, that they have some limitations with their system. So -- and if you look, Governor, there were -- and it's contained in my report that will be coming out -- there are situations where there have been traffic stops around the state by police departments and by certain organizations to ferret out things like false

driver's license and false insurance cards. In some of those stops as much as 25 to 30 percent of the people pulled over don't have proof of insurance.

GOVERNOR SCOTT: How could you afford it? I mean, look at these numbers.

CFO ATWATER: That's the whole point. That's the whole point.

GOVERNOR SCOTT: Gosh, just think of that. You're a family making $40,000 in Hialeah and in three years it goes from 490, what, to -- what is it, 30 -- $3800.

MS. WESTCOTT: Uh-huh.

GOVERNOR SCOTT: But look at these others even, from 294 to 2,090.

MS. WESTCOTT: And that's most concerning -- I mean, some of these -- especially retired couples, I mean, that's definitely people on a fixed income that are having to respond with premium that's quadrupling.

GOVERNOR SCOTT: Okay. Thanks.

MS. WESTCOTT: The working group also covered some areas to identify the cost drivers, that some of the reasons behind why

you see these losses going up so dramatically, and these rate increases going up so dramatically.

And one of the things that was identified very early on -- and there was a presentation by the National Insurance Crime Bureau at one of our working group meetings -- showed that Florida is absolutely prone to auto fraud, auto insurance fraud.

We had a staggering 34-percent increase from 2008 to 2010 for staged accidents in our state; and as many as -- in our cities of Miami, Tampa, and Orlando rank among the top cities in the country for staged accidents in our nation.

As a response, our Division of Insurance Fraud, which I'm sure you see some of the arrests that are made each week on some of these matters, spends approximately 49 percent of their time and resources on PIP fraud. Out of the 13,452 referrals that are made to them for insurance fraud, and that includes health -- other health care insurance fraud, title fraud, any other type of fraud that you can conceive of, we have a system where we're

spending resources, dramatic resources on maintaining a $10,000 benefit.

GOVERNOR SCOTT: And what's the penalty if you're caught?

MS. WESTCOTT: If you're caught without -- oh, excuse me.

GOVERNOR SCOTT: If you're in a staged accident, and so you're caught doing insurance fraud, what's the penalty? Do you know?

MS. WESTCOTT: I'm sorry. I --

CFO ATWATER: Years in prison.

ATTORNEY GENERAL BONDI: Are you talking --

MS. WESTCOTT: Years in prison.

GOVERNOR SCOTT: Is it six months, or is it --

ATTORNEY GENERAL BONDI: I'm sorry, my mike's not on. I know my statewide prosecutor is on the task force with CFO Atwater and we're all over it. I mean, it depends on the --

GOVERNOR SCOTT: Years.

ATTORNEY GENERAL BONDI: -- what they do. But, yeah, it's fraud, it's organized fraud, really.

GOVERNOR SCOTT: Is it hard to prove?

MS. WESTCOTT: Yes.

CFO ATWATER: It can be hard to prove.

MS. WESTCOTT: Yes. And the part --

ATTORNEY GENERAL BONDI: But it can be proven.

MS. WESTCOTT: Yeah, it can. The hard part is too is that, it might be easier to get the penalties and get the arrests in the lower levels of what's going on; in other words, the person that jumped into the car, or the person that, you know, went and signed all the forms at the clinic so that, you know, that the bills could be generated.

But the investigators want to go further than that. They want to try to get into the -- some of the clinic settings, which I'll talk about here later, and those are more difficult investigations, and you'll see why in a moment as well.

But many of the investigations that surround the staged accidents have resulted in arrests and results from looking at what we call PIP clinics. And PIP clinics are generally set up to just treat automobile accident victims.

Oops --

GOVERNOR SCOTT: Can you go back --

MS. WESTCOTT: -- I need to go back. I'm sorry.

GOVERNOR SCOTT: Yeah, can you go back to the one that says health care clinic? Yeah, there you go. How do you get -- what's the --

MS. WESTCOTT: Okay. Health care clinic. That's -- okay. We want to talk about this a little bit. Healthy care clinics, as we said, they're really set up to respond to an auto accident victim. Back in 2003 AHCA was given the responsibility of licensing health care clinics in our state.

In 2004 there were some exemptions that were added to that statute that, you know, probably seemed like a good idea to allow people who were licensed by the Department of Health as a practitioner, certain practitioners, to have a clinic without having to hold a license from AHCA, and they could be exempt from licensure under the statute. And above that, not only could they be exempt, but they don't even have to come say I'm exempt. It's just a self-executing exemption.

So what we have is a situation that created the greatest vulnerability to people setting up clinics for there to be very limited or no oversight of the clinic itself, and again people are receiving care -- if it's not set up for a total fraudulent purpose, there are situations where people are receiving care -- and as AHCA has identified, one of the greatest vulnerabilities is from the fact that you can have this clinic, but then you can offer services in this clinic that are beyond the scope of your license.

One of the examples that they used -- and this slide really deals with the exemption, how there's skyrocketing exemptions in Miami. But I really offer it to say, there is no telling; we don't know. We know we have about 2100 licensed clinics, we have about 8,000 who sought an exemption, and we have absolutely no idea who the rest of those people are or what they're doing.

GOVERNOR SCOTT: Yeah. If it's physician owned, you don't have to file at all, right, you don't --

MS. WESTCOTT: Yes, sir.

GOVERNOR SCOTT: -- have to file for an exemption or anything?

MS. WESTCOTT: Right. But the exploitation comes -- and AHCA really provided some of this data, and some of the data that indicated, one of the licenses that we see a great increase in people seeking, and we believe that many of the clinics are owned is a massage therapy clinic, and in that situation you have a massage therapist who owns a clinic who can at that point have any number of -- a doctor, a chiropractor, a prescription pad, they can -- you know, those prescriptions have been written for whatever the service is that's provided there, any sort of diagnostic --

GOVERNOR SCOTT: You open up a message parlor, whatever it's called.

MS. WESTCOTT: Clinic, yes.

GOVERNOR SCOTT: Clinic. Okay.

MS. WESTCOTT: Therapist.

GOVERNOR SCOTT: Okay.

MS. WESTCOTT: Yes, sir.

ATTORNEY GENERAL BONDI: And I think these are legitimate clinics.

MS. WESTCOTT: They are.

ATTORNEY GENERAL BONDI: They're truly --

MS. WESTCOTT: There are some legitimate clinics.

ATTORNEY GENERAL BONDI: -- Japanese massage parlor, you know, the ones -- no, you know, what I mean, the ones on Kennedy Boulevard in Tampa that are being shut down.

GOVERNOR SCOTT: Let's all change the subject. So it's a massage clinic.

MS. WESTCOTT: Right, right. The clinic's under that license, yes, sir.

GOVERNOR SCOTT: So you get -- and it's an AHCA license?

MS. WESTCOTT: Yes.

GOVERNOR SCOTT: It's an AHCA massage --

ATTORNEY GENERAL BONDI: Clinic.

GOVERNOR SCOTT: -- therapy clinic license. And then you can do anything you want.

MS. WESTCOTT: Right. The technical -- it's a health care clinic, you're licensed and exempt by the fact that you are a massage therapist licensed by the Department of Health, you then can employ whoever you want to in this

facility, and as long as the claim that goes into the insurance company has a prescription that was written for the service -- and just think how hard that is to police when you have no idea who these people are or what they're doing -- that just perpetuates a huge hole for people to exploit the clinic setting.

GOVERNOR SCOTT: And all they have to do is comply with the rules regarding being a massage clinic.

MS. WESTCOTT: Well, and that's -- truly all they have to do is be licensed by the Department of Health.

GOVERNOR SCOTT: Do they --

MS. WESTCOTT: Once you're exempt --

GOVERNOR SCOTT: -- annual review or anything? Oh, they don't do reviews?

CFO ATWATER: Just audits.

MS. WESTCOTT: The licensed clinics receive a review.

GOVERNOR SCOTT: Right.

MS. WESTCOTT: Exempt clinics that AHCA has said you're therefore exempt, it's little more than a registration. If you are an exempt clinic, self-exempting, there's no oversight at

all.

ATTORNEY GENERAL BONDI: And to clarify, on Kennedy Boulevard in Tampa there's been an issue with these bathhouses, they called them Japanese bathhouses, and that's not what this is.

MS. WESTCOTT: No.

ATTORNEY GENERAL BONDI: These are true massage therapists. It's nothing nefarious in that way.

CFO ATWATER: Well, let me be -- the majority of -- there are licensed massage therapists --

MS. WESTCOTT: Yes.

CFO ATWATER: -- that have businesses. The bulk of the ones it is -- that is just my conclusion from being out there, when you have less accidents, less drivers, and 40 percent increase in claims, and this is where the claims are coming from, these are not health care clinics, these are fraud clinics. There are legitimate people out there doing massage therapy work.

MS. WESTCOTT: Right.

CFO ATWATER: What we're getting billed

for is -- is fraud, fraud, fraud, fraud.

MS. WESTCOTT: And I would add, a substantial I think too amount of abuse. Because there is no -- I mean, perhaps you do render that service and it's not a situation where you're just a guy with a fax machine and a desk submitting claims. There's still -- there's nothing that stops that. They're the -- you can bill for as many procedures as you can get on the form at some point.

GOVERNOR SCOTT: That doesn't make sense. I mean, so you can -- you can -- and you're bill -- you're not billing AHCA. I mean, it's never -- they're not doing any Medicaid.

CFO ATWATER: Correct.

MS. WESTCOTT: Right.

GOVERNOR SCOTT: So you're just billing the insurance companies.

CFO ATWATER: Right.

MS. WESTCOTT: Yes.

GOVERNOR SCOTT: So the insurance companies just have to police it.

CFO ATWATER: Right. And have to pay costs first.

MS. WESTCOTT: And I would add, you're

billing mostly PIP because, you know, if you were billing -- and I don't feel bad about using Blue Cross saying they were actually on the working group, look at their -- their analysis on when they break down how -- you know, their coordination of benefits with auto insurers, it's very different. People are not billing for these type of procedures as a practice for their health care and for any other type of managed care setting or setting where those bills are subject to that kind of review.

GOVERNOR SCOTT: Okay. Thank you.

MS. WESTCOTT: Okay. Many -- after discussions, debate also within the worker group seemed to shift back many times to utilization. And while, you know, fraud has been a great discussion topic, we also get to this point where litigation has become a huge issue in the PIP system.

And, you know, whether or not you say that litigation has been driven by the fact that you have legitimate claims that are being denied by the insurance company, or you say that you have people who are billing illegitimate claims or

inflated claims, the pure science is, is that if you look at what the claims -- or the lawsuits that have been filed through -- '09 through '11 -- through 2011, we have an inordinate amount of lawsuits even this last year.

In 2010 we had about 36,000 lawsuits. And this is tracked through the Department of Financial Services service of process. Insurance companies basically have to be served through that office. So they have tracked -- and most of these are county court cases, so 95 percent of what they see for county court cases are going to be PIP -- right now we have through August more than 47,000 lawsuits filed for PIP claims.

GOVERNOR SCOTT: Can we go back? Okay. So the way it works is that you're the massage clinic, and you start making filings, right? So if the insurance company says, gosh, I think you're doing the wrong thing, what happens, what's the process? What's their obliga -- what's the -- where does -- what's the insurance company's obligation, what's their opportunity to say, I'm not going to pay it?

CFO ATWATER: Frankly, that brings -- that puts us right on the slide you're now looking at.

MS. WESTCOTT: Uh-huh.

CFO ATWATER: When they begin to dispute those claims, the lawsuits start to file. And so their ability to try to gain the evidence that they are being -- they're being fraudulently abused in a particular filing, they start an investigation, and some of that -- which we'll get to some of the issues at the end of this presentation as, even over the years we've tied the hands of anybody being able to get solid evidence and testimony to be able to continue on onto the path of not paying the claim, so they start paying the claims, which is what drives up the costs.

GOVERNOR SCOTT: Okay. So are you -- are you obligated for all the legal fees on top of -- like let's say you lose.

CFO ATWATER: Yes, you are.

MS. WESTCOTT: Yes.

GOVERNOR SCOTT: So it's not just the 10,000, you're obligated for whatever costs and legal fees.

CFO ATWATER: That's correct. And there is a whole other question called the multiplier which we may get to later, but, yes, you are.

GOVERNOR SCOTT: Okay.

MS. WESTCOTT: Yeah, it's a big issue.

CFO ATWATER: It's a big issue. Okay.

MS. WESTCOTT: And that leads me to the comment that I think is the most important about litigation, is that utilization of these services is governed by the litigation in this benefit. There is no cost control; there is no review; whether or not that provider provided the service legitimately or inflated a claim; or whether that insurance company, for whatever reason denied that claim, wrong or right, it's going to end up in litigation.

You see the -- many of the charts show that, whereas, you thought when we had a fee schedule come in, okay, now we know everybody is going to get paid a certain amount, that generated more litigation than anything.

GOVERNOR SCOTT: Why?

MS. WESTCOTT: There became debates over whether or not the companies had properly adopted that in their form filing. There were

debates over which utilization -- or excuse me -- which fee schedule gets used at what time because Medicare changes that throughout the year. So all of those issues where you thought you were making this clearer ended up in litigation.

GOVERNOR SCOTT: Thank you. Okay. So the bottom line is, is it's difficult when you've got the problem that you don't -- you don't have to be licensed and so you could have somebody just have a massage clinic, that's step one.

Step two is, is you don't have -- the insurance company is -- has a very difficult time stopping payment because -- and I decide not to pay -- because if they lose, they're going to pay big attorneys' fees.

MS. WESTCOTT: Yes, sir.

GOVERNOR SCOTT: Okay. Those are -- so those are the big issues so far.

MS. WESTCOTT: They are two very big issues.

According to the OIR data call, Florida is above the national average in many instances, including provider charges per claim, average

number of procedures per claim, and the average procedures per bill. And I keep doing that.

GOVERNOR SCOTT: So -- so what's the spread here? The -- so the national is the blue?

MS. WESTCOTT: Yes.

GOVERNOR SCOTT: So that's 80 --

MS. WESTCOTT: National average --

GOVERNOR SCOTT: -- what, 8300?

MS. WESTCOTT: -- is big.

CFO ATWATER: Right.

GOVERNOR SCOTT: That's 8300 and we're at 12-one, is that right?

CFO ATWATER: Yeah.

GOVERNOR SCOTT: So that's three-31 plus seven-38 -- a hundred dollars more? Okay.

MS. WESTCOTT: And my apologies, it's harder to see on this screen.

And also I would call your attention too to the next average procedures per claim. You know, the 2000 -- that 2007 mark where you've got more procedures coming in, that's when the fee schedule, in the two seven -- '07 to '08 and '09 is when fee schedule was going -- was being implemented. So you automatically see

that there is a correlation between the implementation of fee schedule and how many procedures get billed per claim.

GOVERNOR SCOTT: But even before that we were -- we had -- the average was 43 or something, the national average, and we're at 60, right?

MS. WESTCOTT: Yeah.

CFO ATWATER: You're right.

GOVERNOR SCOTT: We're still -- we're --

MS. WESTCOTT: Yeah, we're still above.

CFO ATWATER: Which is why we implemented the fee schedule, and then along with -- as soon as that was implemented, then they just ran up the number of times they performed the procedure.

GOVERNOR SCOTT: This is a pretty big tax on Floridians.

MS. WESTCOTT: And that -- that's the irony at the end of the day is that -- you know, and I said this to the working group: you know, at some point it's lawyers, providers, and insurance companies fighting over a pot of money that the consumer paid in and keeps paying in at an extraordinary level.

Each day seems to be worse.

I'm just going to briefly go over these. I think we've kind of covered the surface here on what we think we need to do. I will briefly talk on the bullets of -- okay. What are we providing and who is providing it I think -- or become huge important issues for us to address legislatively.

One of the things that we did have somewhat a consensus on was an electronic filing system. That was probably a very lukewarm reception from the industry. But the thought behind that is that this is a very manual process. And those who have learned to exploit the manual process do it very well.

However, general practitioners in their office don't want to fool with filing these claims. So generally they don't provide services under PIP.

An electronic claims filing system would give us a better ability to track data, would be able to give us the opportunity to see some of those trends quicker more -- and be more responsive, and perhaps open up the provider base of people who would actually, you know,

give service under a PIP benefit.

Regrettably -- some of the procedures that we see anecdotally as part of the PIP delivery system are -- and this was from one company's reporting data -- that were hot packs and cold packs and massages, and just a whole host of types of procedures that you find generally in a clinic type setting, some are somewhat associated with a chiropractic care. The 2007 OIRC report showed that most of the bills in the PIP system came from or originated from chiro -- from chiropractic care.

So they're -- however, we don't have a universal database that shows us what exactly the services are that are being rendered. Anecdotally we have that. We've asked for that from the insurance companies as well as information regarding how much attorneys' fees are in this setting. We have not received that information after several attempts, open calls in the working group, and requests through the OIR data call. We don't have a wealth of information to say, this is what it is. We're going to try to make one more attempt to ask the companies to be responsive to that.

But we would like to see, before we -- before the legislature has the responsibility of looking at the system -- to see what the major procedures are under -- and who the -- who exactly some of the providers are in this system. And we will make an attempt to do that here in the next 30 to 45 days.

But at the end of the day there still is this overwhelming question about the type of services and who provides them in this system. We need to answer that. Is what PIP has become what the legislature intended PIP to be when we were trying to structure a system that paid for people to be taken care of after an auto accident without having to litigate that issue.

I would suggest that many people will say that limiting services, or limited availability is not a very consumer friendly thing to do. However, if you look at it, 99 percent of the cases, this is not about the insured making a claim; this is about providers and the other people in the system litigating and insurance companies litigating over this pot of money that is what the consumer is paying in.

And once we do get to a point where we have addressed these issues and we have some clarity on reducing costs in the system, if that is where we go, then insurance companies must be made to lower those rates. And we would expect rate filings that would show and reflect on a use and file basis perhaps that companies are lowing those rates overall.

But we have to narrow the system, we have to consider who is providing services and what services are provided, we have to look at the litigation costs, and the insurance companies have to be held to lowering that cost for Floridians. Thank you.

GOVERNOR SCOTT: Thank you -- the -- thank you very much.

MS. WESTCOTT: You're welcome.

GOVERNOR SCOTT: Do policyholders -- are the insurance companies educating policyholders about what this is costing them?

MS. WESTCOTT: Well, you certainly get the education once you get that bill, but I do think that there are some attempts being made. I've seen some fliers go out through the insurance companies.

But traditionally, you know, when an insurance company -- and I think this really goes back to the fact that nobody gets up in the morning and goes, all right, we're going to buy insurance today, I'm excited.

It's a product that you have to have, and you must buy if you're prudent in your decision making. And I think that leaves insurance companies sometimes to not be as aggressive or innovative in the way that they respond to when they see costs rising on a product.

GOVERNOR SCOTT: What do you think insurance rates are going to go up in the next 12 months if we don't do anything?

MS. WESTCOTT: Well, based upon the litigation figures, if we see another exponential rise in the litigation -- and my actuary actually did the projection on -- based upon what's filed so far this year is to come to that number. In the chart I didn't adequately express -- I think that back on the litigation chart, if you look at that, that's basically for every 10 car crashes in our state, there will be four lawsuits.

I would expect another half million -- or

a half billion perhaps, a quarter of a billion to half billion in costs. I mean, it can't be anything other if you have litigation exploding like that. That means that your costs are --

GOVERNOR SCOTT: Do you know what percentage that is?

MS. WESTCOTT: I don't have a percentage. I can get you a percentage, but I would think that if we're at, what, two, two-and-a-half billion at this point, if we went up to three billion.

CFO ATWATER: It would probably be another 35 to 40 percent on an --

GOVERNOR SCOTT: So 35 to 40 percent --

CFO ATWATER: -- on an annual basis, on this kind of a run rate.

GOVERNOR SCOTT: So let's put that in perspective. What's the -- the average Floridian --

MS. WESTCOTT: Uh-huh.

GOVERNOR SCOTT: -- makes, what, 39,000; and the average household is, what, 46, something like that, right?

CFO ATWATER: Yeah.

GOVERNOR SCOTT: So you increase -- if we

increase this -- so what's the average bill?

CFO ATWATER: Oh, yeah, the average -- well, we saw for -- if you took a -- these are two significantly hard-hit communities where they have rooted themselves into the fabric of these -- so you could take a Hialeah family at $3200 on a State Farm policy.

GOVERNOR SCOTT: So at 40 -- if you have a 30-percent increase, that's a thousand dollars.

MS. WESTCOTT: So soon we'll have people paying four, almost perhaps $5,000 for again a $10,000 benefit.

GOVERNOR SCOTT: That's a -- (inaudible).

MS. WESTCOTT: Yes, sir.

GOVERNOR SCOTT: Tell you what, incomes are not going up that fast.

MS. WESTCOTT: Mine's not.

CFO ATWATER: And car accidents are down. I mean --

MS. WESTCOTT: Yeah.

CFO ATWATER: -- this is -- this is the very clear picture that if -- and that's what the Consumer Advocate wanted to just paint for us today -- you have no new drivers, overall

population; you have fewer accidents; and you have a 40-percent increase in claims. And you have all this utilization going up.

Thirty years ago when someone had an accident, they went to the hospital or they went and saw an M.D. The litigation is not coming from hospitals and M.D.s., it's coming over the disputes of how many times can you give a cold pack or a hot pack or a massage to someone, after a questionable event has even taken place. And I think that's where we're all looking at this.

There was great value to this at the time it was established for Floridians. Now when every Tom, Dick, and Harry can provide a procedure that you can't even have an examination under oath to determine whether or not they really have evidence of any of the file that's being billed to you is real. You trap the -- all of us in a position where: pay the claim, or have a lawsuit, and pass the costs on to the honest Floridian just trying to get by, but we demand they have the coverage.

GOVERNOR SCOTT: Well, and think about the families that make $25,000 a year and they have

another thousand-dollar increase after tax.

CFO ATWATER: Yeah, right.

MS. WESTCOTT: Many are going to choose --

CFO ATWATER: That uninsured motorist --

MS. WESTCOTT: -- to go without insurance.

CFO ATWATER: -- number.

GOVERNOR SCOTT: Commissioner, did you have something you wanted to add?

COMMISSIONER PUTNAM: So what is it that makes Florida so bad? How is our law written differently than the other states?

MS. WESTCOTT: Well, I'm -- Commissioner, I'm not so sure that we differ all that much. Some of the other tort -- excuse me -- some of the other states that have PIP like New Jersey and Michigan, New York are struggling with the same type of issues.

New Jersey actually has an extremely complicated utilization overlay for this system, but that's at minimum $250,000 benefit as well. So our benefit is much lower and I think that's why it kind of -- it disproportionately looks worse.

But I don't really think we stand too far apart from many of the other states with large

metropolitan areas. I think there's some commonality, and I think that they are struggling as well with the retention of a PIP system, of a no-fault system.

COMMISSIONER PUTNAM: So are all 10 PIP states above the national average?

CFO ATWATER: No.

MS. WESTCOTT: I don't think so, no.

CFO ATWATER: No. We are clearly a fraud leader. To answer your question, the litigation is more significant here, the number of provider players seem to be more generous here in who we allow to participate in the system. And -- so that national average is meant to be of the PIP players.

So you can see of the 10 that are still hanging on to this concept, we are far exceeding that, and it has been in many -- and regrettably the -- we don't give the insurance company much opportunity -- once a claim is set in motion, there are time limits to hit, and there is -- recent court cases have tossed out the ability for an insurance company to go put somebody under oath and say, I wanted to just be sure I can -- you're here at a health care

clinic, you're looking for the MRI machine, can I just have somebody under oath say that this took place. And --

GOVERNOR SCOTT: Why would --

CFO ATWATER: -- the court cases --

GOVERNOR SCOTT: Why would that be? Why would we not -- why would you not have to do that?

CFO ATWATER: That's -- I -- I -- I -- I would hope that one of the things we can accomplish again is to provide that, tools that we could allow the provider -- the payer in this case, the insurance company, the insurer -- insurer to go in and be able to create evidence necessary to determine, I need to get these people a check right away, or this one we're not paying. But that's how this has fallen out. Our past statutes after the courts looked at them knocked out some of these tools.

GOVERNOR SCOTT: Okay. So what's -- what's the process to fix this? What do we have to do? What's a logical process to try to get this fixed?

MS. WESTCOTT: Well, I would say a first

step would certainly be to try to get a little more data about exactly the types of claims from more than just one company's example. I would like to see the insurance industry come forward with information that would show us exactly -- exactly who we're paying and what for. I don't think that has been determined, as totally discussed, as brought out with data as we would want it to be.

Second, I do think once you get that data, then we have to do kind of a comprehensive analysis of, does the cost and the things that have to be done to this make sense. I mentioned the utilization as in New Jersey, that is a very expensive process. And again things like work comp have it, but they also have a total system that deals with workers' comp claims.

If we do that for a $10,000 benefit here, have we really gone beyond that cost-benefit analysis that we need to do as to whether this is really a viable system for Floridians. And if we get to that point where we say, okay, there is value, and there is value to paying a claim -- or paying for medical treatment for

people, especially information submitted from the hospital association showed that for 36 percent of the people they saw in that emergency room, PIP was the only health care benefit that -- or policy that they had.

So for some people, this is a very valuable thing, and it's valuable for the rest of us because if they don't have that, we all pay for that in higher taxes, we all pay for that in higher health care coverage, we all pay for that in higher auto insurance premiums.

So, you know, there is a personal responsibility under this statute, and it's a valuable thing to have that privilege to drive an automobile in our state attached to -- and then you need to take care of the fact that if you're injured, you can cover that cost. There's value to that. But we need to also see what is the cost of it to us.

GOVERNOR SCOTT: But the bottom line is this is a $900-million tax on Floridians.

MS. WESTCOTT: Yes, sir.

GOVERNOR SCOTT: And you're -- and it's another -- and if we don't do anything, it's going to be another $500-million tax.

CFO ATWATER: Soon.

MS. WESTCOTT: I think it could be, yes.

GOVERNOR SCOTT: I mean, that's what actually it is.

CFO ATWATER: One or two years from now.

MS. WESTCOTT: Yeah.

GOVERNOR SCOTT: It's a tax.

CFO ATWATER: Yeah.

GOVERNOR SCOTT: For the right to live in Florida, we're going to tax you $900 million and we're going to give you -- give it to other people.

MS. WESTCOTT: Right. Because ultimately you're going to pay for that in the premiums. I mean, that is the goal and -- it's to -- it's to -- for an insurance company, it's to have enough money to pay those losses when they come into the company. And so that means the response is, raise premium.

CFO ATWATER: Governor, I might add to your question. I think the PIP system has been extremely valuable in its earliest years for the consumers of Florida; and if we can't return it to that, we need to look at the alternative. The alternative will be less

expensive for Floridians right away, fewer are actually legitimately using it, but it is a value.

And I think that the outline that's presented by the Consumer Advocate is clear. We have to have a limit -- limit -- limit who is -- who are the providers that provide real necessary care that occurs from accidents involving automobile. Not every type of possible service provider that gets a free run at running up the claims.

Secondly, where will those take place? What is the utilization going to be? Put this on electronic filing so it's faster, quicker, and easier for all of us to monitor. Address the litigation that's involved with this system and drive down and immediately call -- and that's one of the things I would hope that the Commissioner could address at some point -- a rate filing as quickly as possible that could go with what the bold changes the legislature has to make.

But I do want to answer one question. You asked about what has the insurance industry done in our efforts to try to address this

situation. Frankly, I would say it's a failing grade.

As upset as I am about watching how all of the -- what I believe significant, overwhelming fraud and abuse that's going on that is being passed on to the consumer; as much as I defend the need for the rate -- which I talked about right off the bat, these are audited statements, these are real losses -- for them to be communicating this to the customers; being on the lookout for the suspicious activity; being encouraged to participate in a staged accident; to provide the Consumer Advocate with the data necessary to know who we're actually paying, they have this data; to provide us with what are litigation costs, they have this data; how significant is the multiplier effect on those lawsuits, they have that data; they could be tremendously more helpful.

And I would hope within the next 45 days before the legislature meets, they'll sit down and they'll provide the information. Just simply believing that this is solely a litigation issue is going to -- is not going to

allow for what are the right providers, what are the right services, all of those things are complete in a wholesome PIP coverage, and it's my hope that they'll participate with us in getting all the information necessary to make the bold changes we have to make. Or if we can't do that, the people of Florida just can't keep paying these rates for this system.

GOVERNOR SCOTT: Why are people going to continue to move to our state if we -- we can talk about how we don't have a personal income tax, we've got a big tax here. We have almost --

CFO ATWATER: Right.

GOVERNOR SCOTT: -- a billion-dollar tax --

CFO ATWATER: Right.

GOVERNOR SCOTT: -- just for the opportunity to live here.

CFO ATWATER: Right.

GOVERNOR SCOTT: All right. Anything else? All right. Thank you, Robin.

MS. WESTCOTT: Thank you.

GOVERNOR SCOTT: Okay. The next presenter will be Scott Wallace providing an update on

Citizens Property Insurance. Good morning.

MR. WALLACE: Good morning. How are you today, Governor?

GOVERNOR SCOTT: Great.

MR. WALLACE: Good morning, Commission members. And, Governor Scott, with your permission, I'll proceed.

GOVERNOR SCOTT: Absolutely.

MR. WALLACE: Thank you. First of all I would like to thank -- thank you for allowing me to address the Financial Services Commission today. There are four general areas that I would like to discuss today: Those are policy growth and demographics, claims paying ability and assessments, statutory and operational issues that affect the size of Citizens, and the status of implementing the provisions of Senate Bill 408.

This slide represents some of our policy growth over the years. Citizens currently has approximately 1.4 --

GOVERNOR SCOTT: Scott, could you stop for just -- excuse me for a second. Can you just give an overview of 408, the main three or four points?

MR. WALLACE: Pardon me?

GOVERNOR SCOTT: Can you just go over the intention of 408 and what the main points are --

MR. WALLACE: Sure.

GOVERNOR SCOTT: -- so that everybody understands it?

MR. WALLACE: It will take a while to get to it.

GOVERNOR SCOTT: Are you going to go through 408 later on?

MR. WALLACE: Yeah.

GOVERNOR SCOTT: Just -- then wait. Then wait. I'm sorry. You can go back.

MR. WALLACE: Okay. As stated earlier, Citizens currently has approximately 1,476,000 policies in force today. This line shows the policy counts over time for Citizens in all three accounts, that includes the personal lines account, the coastal account, and the commercial lines account.

As the slide illustrates, in January 2010, our in-force policy count was 1,030,000; as of January of 2011, that had grown to 1,283,000; and as of October 30th, 2011, our in-force

policy count is as I just stated, 1,476,000 policies. This represents a 43-percent increase in just 21 months. Our projected year-end in-force policy count is estimated to come in at approximately 1,490,000 policies.

As this slide indicates, the personal lines account has been our most volatile of all three accounts. Between January '10 and -- January 2010 and September 30th, 2011, we have grown the PLA account by approximately 309,000 policies, representing a 63-percent increase.

GOVERNOR SCOTT: Scott, can you explain the difference between the three types of accounts?

MR. WALLACE: The coastal account is all of the businesses written in what was formerly designated as the high-risk territories. Those high-risk territories generally have a boundary of approximately one -- or 1500 feet inland from the sea water. There are exceptions to that such as the Miami area in which the HRA or the coastal account stretches into and all the way to interstate 95.

The PLA account is for personal residential business that is written, so to

speak, inland or outside of the coastal account.

And the CLA business is the commercial residential business that is written throughout the state which includes condominiums, homeowners associations, apartments, and so on.

GOVERNOR SCOTT: And the original purpose for Citizens was to cover who?

MR. WALLACE: The original purpose of Citizens?

GOVERNOR SCOTT: Right.

MR. WALLACE: Well, to provide insurance to those who are unable to obtain insurance in the voluntary market.

GOVERNOR SCOTT: Throughout the state?

MR. WALLACE: Yes. All right.

By contrast, over the 15 years, the coastal account, or formerly known as the high-risk account, had remained relatively flat with the lowest in-force policy count being in 2002 with 397,000 policies, and the highest in 1996 with 465,000 policies. Today we stand at 450,000 policies in force in the coastal account.

The commercial lines account is currently -- consists of 8,128 policies, which is down from the high of 9,126 policies in 2009. While this does represent a small policy count, I should note that the total exposure still remains at just a hair over $40 billion, which is significant.

With regard to our policy growth, I think it is important to also look at the demographics of our book of business. A couple of key points to keep in mind, the insured values of our homes, 97 percent of the homes in the personal lines account are insured for less than $400,000, and 82 percent of the homes in the coastal account are insured for less than $400,000.

When we look at the age of homes, we find that 78 percent of the homes written in Citizens in both the personal lines account as well as the coastal account are more than 20 years old. That same trend tracks right through our mobile home business in which 75 percent of our mobile home business are on structures that are more than 20 years old.

One key important thing I would like to

also point out is our geographic concentration. New business written since January of 2010, we see that 71 percent of new personal residential policies are being written in southeast Florida and the greater Tampa Bay area.

Going to the next slide --

CFO ATWATER: Scott, is that new business in southeast Florida, is it CLA, or is it PLA, or -- it doesn't look to be coastal.

MR. WALLACE: PLA primarily.

CFO ATWATER: Okay.

MR. WALLACE: Yes, it is.

Okay. The next slide is a summary of our assessment structure. This is a refresher for you. I believe this was provided to you in June, but it does provide a graphical depiction of the order in which Citizens levies assessments which is illustrated in some of the following slides.

Excuse me. Any questions?

GOVERNOR SCOTT: Sure. Let's go through that for a second. Okay. So how does this work?

MR. WALLACE: Okay. If there is -- excuse

me -- a deficit in any one account --

CFO ATWATER: You know, Governor, I might suggest that if he leaves that on the screen and you pull two slides further, you'll see the actual impact on the consumer as he talks about how the hierarchy works.

GOVERNOR SCOTT: Okay.

MR. WALLACE: Okay.

GOVERNOR SCOTT: That's great.

MR. WALLACE: But I will go through this pyramid. With the Citizens policyholders surcharge, the first line of defense is Citizens policyholders. If there is a deficit in any one account, Citizens has the ability to provide or assess a Citizens policyholders surcharge, up to 15 percent per account to satisfy the deficit. In other words, a 45-percent increase of all three accounts were impacted.

GOVERNOR SCOTT: I mean, what's the average -- so a $400,000 home, what's the average premium?

MR. WALLACE: I think our average premium runs about $2300 on our book of business.

GOVERNOR SCOTT: Okay. So they're going

to have -- well, I guess it depends on the --

MR. WALLACE: Yeah. But we will show that in future slides for you.

GOVERNOR SCOTT: Okay. Great.

MR. WALLACE: All right? If a deficit still remains, then a regular assessment would come into play in which case all policyholders, except Citizens policyholders, would be assessed up to six percent per account, so a maximum of 18 percent.

And, thirdly, if there continues to be a deficit, then we would go to the emergency assessment, which is an assessment that could be up to 10 percent per account per year until the deficit is satisfied. So if we can go through some examples, I think that would be helpful for you.

All right. This is -- we'll start out with some of the worst-case scenarios. On the left side of the slide, this shows a one in 100-year event, which would require the exhaustion of Citizens surplus and levy as a 45-percent Citizens policyholder surcharge; the levy of regular assessments in each of the three accounts; in addition to a 19-percent

emergency assessment on the coastal account only. The emergency assessment would apply to all policies for just -- well, for approximately two years.

Now, if we look at the right side of the slide, this second pie on this slide represents the largest hurricane recorded in Florida history, that would be the Great Miami Hurricane of 1926, and it was greater than a one in 100-year event. And this shows the potential impact on Citizens if the storm struck today with the same path as it did in 1926.

As you can see from this storm -- or as you can see, this storm is very similar to the one in 100-year event. The significant difference between the two is the significant impact in the emergency assessment in the coastal account.

In the one in 100-year event, which is a more generic event, we see that the total assessment in the emergency account is 19 percent. In the Great Miami Hurricane, it would be 25 percent.

On the next slide we provide examples of

how that effect -- how the effect of assessments on both Citizens and private insurer policyholders.

So looking at the one in 100-year hurricane event, you can see that the Citizens policyholder would have a surcharge in the first year of $1100 in addition -- that would go on top of his $2,000 premium. I mean, we're using an average -- a typical premium based on a thousand -- or $2,000 --

GOVERNOR SCOTT: So -- and the typical premium is 2300?

MR. WALLACE: Yeah.

GOVERNOR SCOTT: And the average premium is 20 -- yeah.

MR. WALLACE: Yeah. I mean, looking at it -- we tried to use some round numbers, so if you want to know --

GOVERNOR SCOTT: Yeah.

MR. WALLACE: -- what it was for 3,000 or 4,000 --

GOVERNOR SCOTT: You could do that.

MR. WALLACE: -- you could easily --

GOVERNOR SCOTT: But the average person -- the average premium is $2300.

MR. WALLACE: Right.

GOVERNOR SCOTT: What do you think the average person has in the bank?

MR. WALLACE: In the bank?

GOVERNOR SCOTT: Yeah. How much money do they have, I mean, the average household have in the bank?

MR. WALLACE: In these economic times, very little.

GOVERNOR SCOTT: So how are they going to write an $1100 check?

MR. WALLACE: That's going to be a real challenge.

GOVERNOR SCOTT: And let's say they can't write the $1100 check, what happens?

MR. WALLACE: I would imagine they no longer receive insurance.

GOVERNOR SCOTT: So our plan is relying on something that can't happen, is relying on the fact that these people can't write a check, right?

MR. WALLACE: Well, assuming that they can't write a check, not everybody is in that situation where they can't write a check, but this is something that was created by the state

legislature, we are carrying out that role and responsibility.

GOVERNOR SCOTT: So does the -- what sort of -- when you -- you sell a policy, does the person know that this is going to happen, they have -- this risk?

MR. WALLACE: Well, there's been a great deal of talk in the media and stuff, many people have become aware of assessment capabilities. But in addition to that, under Senate Bill 408, one of the requirements is to provide a -- require a signed statement from the applicant acknowledging that he knows his policy will be assessed or it can be assessed.

GOVERNOR SCOTT: And that went -- when did that go into effect?

MR. WALLACE: That has -- the form was approved in October, that will go into effect January of 2012.

GOVERNOR SCOTT: So what -- have you done any surveys to see what percentage of Floridians realize that they have this risk of assessment?

MR. WALLACE: No, we haven't.

GOVERNOR SCOTT: Okay. So -- all right.

So we have potential -- it's really higher than this because it's -- the average premium is $2300, so it's more than 1100, but you say it's $1200. The average Floridian you believe doesn't have the money.

So say they don't write the check; so if they don't write the check, then what happens? So I'm a home -- I'm a home -- homeowner, I had $10,000 worth of damage, I can't write the check. And so Citizens just cancels my policy. Is that what happens?

MR. WALLACE: Well, I believe under the rules that's -- it would be for nonpayment of premium.

GOVERNOR SCOTT: Yeah, but -- yeah. Okay. So let's go through -- so step one, they can't write the check -- and you've got to have the money right away, because you have -- you're expected -- Citizens is expected to pay everybody else, right? No, I guess there is a penalty --

MR. WALLACE: It is assessed at the policy renewal. The policyholder's surcharge is assessed at policy renewal.

GOVERNOR SCOTT: So how does Citizens pay

out the claim then?

MR. WALLACE: We have liquidity built up so that we can pay the claim.

GOVERNOR SCOTT: Okay. Let's go back a slide. You have a surplus now of fif -- of how much, 5.7 billion?

MR. WALLACE: Yes.

GOVERNOR SCOTT: So if the consumer -- where's the consumer paying in this one?

MR. WALLACE: That would be -- it would be -- Citizens policyholder surcharge, that is levied at policy renewal.

GOVERNOR SCOTT: That's the one billion one seventy-two? Okay. And then what's --

MR. WALLACE: Yes.

GOVERNOR SCOTT: Okay.

MR. WALLACE: And then you have regular assessments, and that would be three billion 606. And that is levied within 30 days after the event.

GOVERNOR SCOTT: So in this case --

MR. WALLACE: And that is levied against the insurance companies.

GOVERNOR SCOTT: Okay. In this case, half the money is relying on somebody being able to

write a check, right? Half -- if you look at this -- there's $23 billion probable maximum loss, half of this -- approximately half of this money, somebody after the fact has to be able to write a check.

MR. WALLACE: Correct. And that would be -- that would hold true ultimately with all of the policyholders regardless of the assessment.

GOVERNOR SCOTT: And why would we ever believe people could write a check?

MR. WALLACE: I think the --

GOVERNOR SCOTT: I mean, we know no one has any money in the bank; it's very difficult.

MR. WALLACE: Well, I think that's a question for the legislature to answer.

GOVERNOR SCOTT: I guess step one without the legislature: are we -- so -- so that you -- you think -- what percentage of people today that have a policy do you think realize they have this risk?

MR. WALLACE: I would guess maybe 40 percent. But that's an estimate on my -- that's my guess.

GOVERNOR SCOTT: And they realize that if

they can't write a check, they lose -- so if they have a $10,000 claim, they can't write their check for $1100, they lose their $10,000. Is that -- I mean, is that the way it works?

MR. WALLACE: Well, the claim would not be denied because the claim is already filed.

GOVERNOR SCOTT: So they'd have a right to the claim, we don't have the right -- we don't -- Citizens would not have the money to pay the claim, right?

MR. WALLACE: But forward-going coverage would be denied.

GOVERNOR SCOTT: Right, right. And then I guess you're right, Commissioner, they would lose -- because they don't have insurance, then they would lose their mortgage. That's a pretty good system.

ATTORNEY GENERAL BONDI: Hold on then -- I was just told, you don't even have to own a home to be assessed, correct?

MR. WALLACE: Correct. I mean, this would be on all policies --

ATTORNEY GENERAL BONDI: All policies.

MR. WALLACE: -- it would be second and

third, the emergency assessment and the regular assessment go through the base similar to the Florida Cat Fund, which is --

GOVERNOR SCOTT: And I guess the additional point, Attorney General, is that this -- on this example of the 2,000, this is just their homeowners policy.

ATTORNEY GENERAL BONDI: Right.

GOVERNOR SCOTT: So that doesn't include what would be under their auto insurance policy, or their life insurance policy --

ATTORNEY GENERAL BONDI: Yeah.

GOVERNOR SCOTT: -- or their disability policy, or whatever policy they had --

MR. WALLACE: Well, if we can go to the next slide, I can clarify that a little bit better.

All right. Here you have -- in the first column you have a Citizens policyholder, they're going to be assessed $1100 in the first year while a property -- non-Citizens property owner would be assessed $433. And because the emergency assessment is not pure -- goes into the second year, all policyholders in the State of Florida would be assessed an additional

$200 -- $180 in the third year.

GOVERNOR SCOTT: I still think -- I still think the way we're looking at this is that: (1) we know there's a significant number of Floridians that don't have a dime in the bank, live paycheck to paycheck. They're going to get assessed, they don't have the money. They don't even know that they have this assessment, right?

CFO ATWATER: Most don't know, most don't know.

GOVERNOR SCOTT: And then you're going to cancel their policy, and then they don't -- you're right, Commissioner, they're going to lose their mortgage. Okay.

CFO ATWATER: Now, Scott, you mentioned at renewal. Do you want to just offer up what payment plan they would have at renewal?

MR. WALLACE: A Citizens policyholder?

CFO ATWATER: Right.

MR. WALLACE: Well, in this situation of a one in 100-year event, they would receive a paid bill for $3100 under this one in 100-year scenario, they could go to a quarterly payment plan if they so choose, or pay the premium up

front, or I believe we also have a six-month payment plan.

CFO ATWATER: In the 31 -- in this example, the 3100, the 2,000 will be their normal coverage for the coming year --

MR. WALLACE: Correct.

CFO ATWATER: -- and 1100 now embedded to make it a $3100 bill --

MR. WALLACE: Correct.

CFO ATWATER: -- and they could go to a quarterly payment.

MR. WALLACE: Correct.

GOVERNOR SCOTT: Yeah. But the fallacy of that is that Citizens is obligated to pay these claims out. They don't have the money. So you have a $10,000 claim, you're not getting paid.

CFO ATWATER: I -- I couldn't agree more with that. There's probably -- what's our -- what's our number now, about -- what's our reserves now?

MR. WALLACE: We currently have in surplus about $5.7 billion.

CFO ATWATER: 5.7 billion. So that will take us a bit of time --

MR. WALLACE: Right. And --

CFO ATWATER: -- to pay out.

MR. WALLACE: -- if it's a severe hurricane such as this, then we would also have -- the next step would be --

CFO ATWATER: The Cat.

MR. WALLACE: -- the Cat Fund; and then after that in the coastal account we have private reinsurance that kicks in; and then future assessments, emergency assessments, and so on.

GOVERNOR SCOTT: Right.

COMMISSIONER PUTNAM: Well, the assessments -- the assessments, are they designed to pay for the event, or are they your bonding mechanism to secure the reinsurance and the deals that we do with Warren Buffett?

MR. WALLACE: No. The assessments are designed to cover the deficits created by the storm.

COMMISSIONER PUTNAM: So their future -- they're -- like to the Governor's point, they're the promise of future payments for something -- for a check that's got to be cut to immediately get a roof back on a house. So --

MR. WALLACE: Correct.

COMMISSIONER PUTNAM: -- what -- so it's up to the state to close that -- to cash flow that.

MR. WALLACE: Correct, correct.

GOVERNOR SCOTT: So how does the state do it? Where is the money if the state does it?

MR. WALLACE: Through the assessment process. I mean, we would just keep on assessing those who are paying until -- until such time as the deficit was cured.

GOVERNOR SCOTT: I mean, the state's not -- the state has no financial obligations.

MR. WALLACE: Correct.

CFO ATWATER: Correct.

GOVERNOR SCOTT: None. Okay. So --

COMMISSIONER PUTNAM: Theoretically.

GOVERNOR SCOTT: Yeah. So by contract the state has no financial obligation. So -- okay. All right. So it's still -- let's go back through. The way this is going to happen is: we have the hurricane, we -- it's past what they can pay, we do these assessments, the homeowner can't pay, we don't have the money to give to the homeowner to fix their house,

Citizens cancels their policy, doesn't fix their house, and they lose their mortgage.

MR. WALLACE: No. We would still be obligated to fix their house.

GOVERNOR SCOTT: You don't have the money.

ATTORNEY GENERAL BONDI: How?

GOVERNOR SCOTT: You don't have the money. How would you have the money --

MR. WALLACE: We do have claims-paying ability. I mean, we do have $16 billion in liquid funds in order to pay claims.

GOVERNOR SCOTT: Okay. Sixteen, but the claims are for 20 -- I thought the claims were for 23 billion.

MR. WALLACE: Well, we would have to do some post-event bonding.

ATTORNEY GENERAL BONDI: Wait, I'm sorry. Where does that money come from? You've lost me. I don't see how we can afford to pay these.

MR. WALLACE: We have $16.7 billion in claims-paying ability right now.

ATTORNEY GENERAL BONDI: Sixty?

MR. WALLACE: Sixteen --

ATTORNEY GENERAL BONDI: Sixteen.

MR. WALLACE: -- billion. If the claim came in -- or the total dollar amount came in at 23 billion, we would have to do further assessments and do some external bonding --

ATTORNEY GENERAL BONDI: And so where --

MR. WALLACE: -- post-event bonding.

ATTORNEY GENERAL BONDI: -- explain to me where that money would come from, the difference.

MR. WALLACE: We would go out, raise the capital in the bond markets, issue the debt, take the cash to pay the claims, and then have to put that on future assessments to policyholders.

ATTORNEY GENERAL BONDI: And you have the ability to do that in the event of a catastrophic event?

MR. WALLACE: Yes.

GOVERNOR SCOTT: So -- are you talking about that -- Scott, do you talk about that later, how you do that? Or is there a slide on that?

MR. WALLACE: We don't have a slide on that today.

GOVERNOR SCOTT: So it's a how -- so how do you -- so how do you do that? So you go -- all right. So you right now -- just make sure, let's look at this. When you've got -- you've got -- let's go back to your slide 5 again.

You've got $5.7 billion worth of surplus. Okay. The next line -- so the reimbursements are from who?

COMMISSIONER PUTNAM: That's the Cat Fund.

GOVERNOR SCOTT: FHCF reimbursements, that's the Cat Fund?

COMMISSIONER PUTNAM: Yes.

GOVERNOR SCOTT: Okay. And I thought we -- the Cat Fund was significantly under water.

CFO ATWATER: Governor, I think -- I think you're right on target. And I don't -- everything that you're asking is right on target. I might suggest to you that it's not this slide that is my greatest concern.

GOVERNOR SCOTT: Okay.

CFO ATWATER: It's this slide happening twice is my concern.

GOVERNOR SCOTT: We can't even do it once.

CFO ATWATER: Well, but I do want you to know that if it happens one time, the cash flow of us paying claims out to the tune of $24 billion, by the time we can get to appropriately working as fast as we can and should for the consumers of Florida, by the time you work through the reserves; the Cat Fund dollars; and you start getting into those, who are paying quarterly, your cash flow is probably going to work the first time. But you're asking a right question.

This is -- you can't pull this off. You can't pull the rabbit out of the hat too many times.

GOVERNOR SCOTT: You would never organize your life like this.

CFO ATWATER: Never, no. Well --

GOVERNOR SCOTT: Never. I mean --

CFO ATWATER: So that's -- let's say -- you're absolutely right. I just -- we're laboring over whether the cash flow would work once.

MR. WALLACE: Right.

CFO ATWATER: It's going to probably work once. It's not going to be good, and it's

not -- it's not --

GOVERNOR SCOTT: So we paid twice.

CFO ATWATER: Then you're gone. Yeah, then you're --

GOVERNOR SCOTT: So it happens twice, what's your plan?

CFO ATWATER: That's a good -- that's a very good question, and I don't think people have thought that far ahead of it. And quite frankly, even in the private -- even in the private industry, if you receive two one in 100-year events year after year, I think the entire state would have some deep, serious trouble.

COMMISSIONER PUTNAM: And they both don't have to be one in a hundred -- you get the first one that's the one in a hundred, and then -- and then just have the normal event the next year after you're already broke. You don't have to paint this sci-fi picture. You just --

CFO ATWATER: Well, I have --

COMMISSIONER PUTNAM: And history shows that we have busy seasons. It's not episodic. It's back to back in the '20s that got us the

Hoover Dike. It's back to back in '04-'05. So just one of those seven in '04-'05 had been the one in a hundred we would have been out of business when the next six came through.

MR. WALLACE: Correct. And I dare say that the private industry would have very, very similar problems.

CFO ATWATER: And to -- if I could say to the Commissioner's point, in '04-'05 we had 820,000, 850,000 policies. Today it's 1.4 million.

MR. WALLACE: Correct.

CFO ATWATER: So this is getting to where you would -- you'd have the stress much quicker than your ability to absorb some of the earlier with those kinds of reserves --

MR. WALLACE: Correct.

CFO ATWATER: -- which we've burned through before.

MR. WALLACE: Right.

CFO ATWATER: So that's why it is -- you're absolutely correct, one of these we can handle, but this is not how to do it.

GOVERNOR SCOTT: Okay. So let's make sure I understand something. So when you go back --

so the regular assessment, that's to policyholders, right?

MR. WALLACE: Pardon me?

GOVERNOR SCOTT: The regular assessment is to policyholders.

MR. WALLACE: Yes. To Citizens -- to policyholders outside of Citizens.

GOVERNOR SCOTT: Okay. The emergency assessment is to the companies, right?

MR. WALLACE: No. The emergency assessment is to all policyholders in the state.

GOVERNOR SCOTT: Okay. So when do you -- okay. So I thought we had to eventually go after the -- we were able to go after the insurance companies.

MR. WALLACE: That is in the regular assessment --

GOVERNOR SCOTT: Oh, that's in --

MR. WALLACE: The first assessment --

GOVERNOR SCOTT: -- the regular assessment?

MR. WALLACE: Yeah. That's in the regular assessment. And that would be to policyholders other than Citizens.

GOVERNOR SCOTT: Okay. And if a company is not able to pay, what happens?

MR. WALLACE: We -- we keep assessing the other companies until we reach the dollar threshold. We keep pushing the assessment layers down further and further.

GOVERNOR SCOTT: So if -- so does that create -- so it creates an economic incentive as an insurance company not to have a lot of money, because that way you don't -- you never have to pay the regular assessment because you'll go to the next person, right?

MR. WALLACE: Well, and -- forgive me, but I don't know the penalties if they don't pay that. I don't know if there is a regulatory rule that says, you know, they're kicked out of the state or what have you.

GOVERNOR SCOTT: But I want to be out of the state.

MR. WALLACE: Maybe so.

GOVERNOR SCOTT: So you have -- you have an ec -- (inaudible) this is right. So you would have an economic incentive never to have that big of an insurance company, right? Because if they just keep going to the next

insurance company, why would you want to do business here?

CFO ATWATER: I think if I were to maybe speak to the mindset, I don't think they would intentionally maneuver to create that condition. I think they though, as a brand name trying to do business in the State of Florida, would look at -- as you know, the preciousness of a brand name -- they're going to be taking this assessment and sending it directly through to their customer while they've advanced the dollars. Okay. And --

GOVERNOR SCOTT: If they have them.

CFO ATWATER: If they have them, if they have them. And again I don't think they would manipulate the process just to accomplish that objective. But I think they all see this as -- they would see this as: So what I've worked hard for to develop my brand and take risks in the marketplace, I'm now having to pass through a burden to my customer on an assessment that they think is coming from my brand name. They're not going to figure all of this out, I've just sent them a $433 bill, I think by this example, whatever the dollar is.

MR. WALLACE: Uh-huh.

CFO ATWATER: And they're going to go, what's the story. You know, I thought I was with you, I thought I was well covered; then they have to explain all of that.

I don't think they're going to manipulate reserves to not participate. I think they see this as you're assessing my client and I'm taking all the risk with my client, and it's my brand that's at stake here, and if I'm here, let's have rate adequacy and I'll take the client myself, and we'll all work this out without you. I think that would be their perspective.

MR. WALLACE: If I can just say a couple of comments as well. I mean, as we know with the history of Citizens and the insurance industry in general, it's gone through some difficult times, periods of frozen rates, periods of glide path, while at the same time during that period people have argued that the rates are woefully inadequate each year we file for a rate increase and other companies do as well.

The fact is, this is one of those

situations, do you pay me now or pay me later? What -- with Governor Scott's question is: Can somebody afford an $1100 a year payment if the actuarially sound rate was put in place, you'd have far less likelihood -- or probably less likelihood and less dollars in the event of a true catastrophic event hitting had we been charging year over year and building surplus, as we should, using actuarially sound rates and even on top of that or better yet that are noncompetitive.

COMMISSIONER PUTNAM: Is the actuarially sound rate greater or less than the one-time assessment that they would face?

MR. WALLACE: I would have to calculate that. We could figure that out pretty quick.

GOVERNOR SCOTT: Okay. We've got you off your presentation, so why don't you go through what you want to show us and -- because I know you have more stuff you want to show us.

MR. WALLACE: Okay. What slide are we on now?

GOVERNOR SCOTT: I think we're here.

MR. WALLACE: Yeah. Okay. We have provided a number of additional examples for

you to demonstrate the potential impact of assessments for single -- large single events and multiple storm scenarios as represented in 2004-2005 if they occurred today.

I think it is important to note that in all of the scenarios which follow except for Hurricane Andrew, including a repeat of 2004 and 2005 storm seasons, there are no deficits triggered in the PLA or CLA account. Notwithstanding the continued growth of those accounts, which does represent our best opportunity for depopulation to the voluntary market, our greatest assessment exposure and rate need continues to be in the high-risk coastal account.

GOVERNOR SCOTT: I guess -- I guess, Scott, the risk is that if you have -- even if you just have a 2004, then your surplus is going to be down to what, a billion five or so? The risk is you have a 2004, and then you have a 2005, and then you have a 2 -- every year, right?

MR. WALLACE: Yeah. If you had all the storms take place -- if you had 2004 repeat itself, yes, our surplus would be depleted

largely.

GOVERNOR SCOTT: Yeah.

MR. WALLACE: And if you had a 2005 same set of circumstances repeat itself, we'd be -- we'd have a much lower surplus.

GOVERNOR SCOTT: At today's rates, what do you generate in surplus a year?

MR. WALLACE: We generate close to 800 to a billion dollars assuming no hurricane.

GOVERNOR SCOTT: Yeah, okay. So this assumes, like if you had a 2004, if -- well, if you're at 5.7 now, you generated 6.7, and you spend out four, you couldn't do it two years in a row.

MR. WALLACE: Correct, correct. Now, if we -- up to the next slide. This just reinforces what I said.

GOVERNOR SCOTT: Scott, you don't know what -- you don't know -- off -- right -- standing here right now, you don't -- you could come back to us, but you don't know what today would -- exactly what the actuarially sound rate is, do you?

MR. WALLACE: Well, it varies by territory.

GOVERNOR SCOTT: But overall you don't know.

MR. WALLACE: I believe we're still seeking an overall territory rate increase -- overall statewide increase of approximately 35 percent.

GOVERNOR SCOTT: So -- okay. So I see what you're saying. So a $2300 policy would be 35 percent more.

MR. WALLACE: Yes. And let me reassure you that that's very deceiving because some territories are calling for --

GOVERNOR SCOTT: Yeah.

MR. WALLACE: -- 400 percent while other territories don't need any rate --

GOVERNOR SCOTT: Right.

MR. WALLACE: -- increase.

GOVERNOR SCOTT: Yeah. If you're in Sebring, you probably don't have a lot of risk; but if you're in Naples, you do.

MR. WALLACE: Yes.

GOVERNOR SCOTT: Okay. Did that answer your -- Commissioner, did that answer your question?

COMMISSIONER PUTNAM: Somewhat.

GOVERNOR SCOTT: Okay. Okay.

MR. WALLACE: All right. This just is a backup slide to the --

GOVERNOR SCOTT: Yeah, we know --

MR. WALLACE: -- circle so we can move on from there.

In this situation in slide 9, if we looked at the losses created in 2004 and 2005 collectively, so we had all eight storms hit, there would be both a Citizens policyholders and a regular assessment in the coastal account but still no use of the Cat Fund recoveries, no assessments in the PLA or CLA account, and no emergency assessments would be applied.

GOVERNOR SCOTT: Let me make sure I -- so if you had the 2004-2005 hurricanes all in one year --

MR. WALLACE: Yep.

GOVERNOR SCOTT: -- that's what this one is. So you do -- so you're part of a -- is that policy surcharge issue, that's on the next page, 300 bucks?

MR. WALLACE: Right.

GOVERNOR SCOTT: And then regular assessment is the -- everybody?

MR. WALLACE: Yes.

GOVERNOR SCOTT: That's 85 bucks.

MR. WALLACE: All right.

GOVERNOR SCOTT: Okay.

MR. WALLACE: By contrast -- you know, going back to the slide with the circles here, or the pies. By contrast if Hurricane Andrew occurred today, we would rely on Cat Fund reimbursements, and private reinsurance, policyholder surcharges, and regular assessments.

GOVERNOR SCOTT: And, Scott, I guess it's a different discussion to understand what the chance that the Cat Fund can pay, it is, right? Do they -- do they actually have the ability to pay.

MR. WALLACE: Well, according to the -- to the latest reports that I've heard and read about, they don't have it in hand at this point in time. Whether they could collect those upper layers of dollars in today's marketplace --

GOVERNOR SCOTT: Yeah.

MR. WALLACE: -- might be a difficult challenge.

GOVERNOR SCOTT: And so you're -- what percentage of the Cat Fund are you? How much of your -- if I'm saying that right. So if there's -- if there's an Andrew and you have a claim, do you know what percentage of the money that the Cat Fund has to fund -- because they have to fund all insurance --

MR. WALLACE: Right.

GOVERNOR SCOTT: -- companies, right?

MR. WALLACE: I believe we represent 30 to 40 percent.

GOVERNOR SCOTT: Thirty -- how much?

MR. WALLACE: Thirty to 40 percent of the Cat Fund.

GOVERNOR SCOTT: Okay. Thirty to 40. All right, thanks.

MR. WALLACE: So if we move on to the next slide?

GOVERNOR SCOTT: Yeah.

MR. WALLACE: Okay. Again this just shows the combined 2004-2005 storm seasons basically as a single event. You can see what the assessments would look like. And again in both the 2004 and 2005 combined event situation, and in Hurricane Andrew, there would be no

emergency assessments applied. All right.

If we can move on to the next slide, I would like to talk about current statutory language that may encourage growth to Citizens. You have seen the slides demonstrated the recent growth that Citizens has experienced which needs to be reduced. There may be a variety of factors that have influenced this growth, and I would like to now discuss the statutory and nonstatutory opportunities to reduce Citizens.

GOVERNOR SCOTT: Hey, Scott, can I ask you a question?

MR. WALLACE: Uh-huh.

GOVERNOR SCOTT: On the first one, on the 10-percent cap on rates, that's like if you were Sebring, you might not need that increase of rates at all, right?

MR. WALLACE: Right.

GOVERNOR SCOTT: So but if you're in Naples you might need to raise it a hundred percent. I don't know what -- got the right numbers.

MR. WALLACE: Right.

GOVERNOR SCOTT: So what this says is that

you can't raise it in Naples but more than 10 percent.

MR. WALLACE: Correct.

GOVERNOR SCOTT: So there's no glide path here. Because the risk is Naples, Miami. So this is a joke as a glide path --

MR. WALLACE: That's --

GOVERNOR SCOTT: -- 10 percent a year.

MR. WALLACE: -- a very good point.

GOVERNOR SCOTT: Okay. All right.

MR. WALLACE: As you know, there's a 10-percent cap on rate increases for Citizens policyholders. Every time a private insurer is granted a rate increase greater than 10 percent, the rate gap between Citizens and those in the private market is making us even more competitive. We're being outpaced by a lot of the approvals. All right.

Moving on. Rates are not required to be noncompetitive. In this regard, supplementing current statutory language requiring rates to be actuarially sound with a provision that rates also be noncompetitive would certainly work to address this issue.

In terms of the 15 percent eligibility

rule, under the current law -- or under current law, an offer of coverage with a private insurer does not necessarily disqualify an applicant for Citizens coverage if the private insurer's offer is more than 15 percent.

Another item that is driving more business to us is the perpetual statutory eligibility. Florida now requires that only an applicant demonstrate his initial eligibility into Citizens, and once covered by Citizens, is no longer obligated to re-establish statutory eligibility within Citizens.

There are also barriers to depopulation. Private insurers frequently express frustration with the fact that either the policyholder or the agents present barriers to policy removal. This pertains to the law that provides for consumer opt out and consumer choice. Where if a depopulation offer is made, the consumer can choose to opt out and stay with Citizens, or the agent may for some reason decide, I don't want to leave Citizens and keep it in Citizens as well.

Takeout's not available for surplus --

GOVERNOR SCOTT: Excuse me.

MR. WALLACE: -- lines companies.

GOVERNOR SCOTT: Excuse me, Scott. Does the agent have an economic incentive to stay in Citizens? Do you pay higher premiums?

MR. WALLACE: Higher commissions?

GOVERNOR SCOTT: I'm sorry, commissions.

MR. WALLACE: I don't believe we pay higher commissions, no.

GOVERNOR SCOTT: But you don't pay lower, you pay the market.

MR. WALLACE: Fairly close to the market.

GOVERNOR SCOTT: Yeah.

MR. WALLACE: Okay. Surplus lines companies. In 2010 surplus lines companies wrote $274 million of personal and general and commercial residential premium in the State of Florida. It may be time to now consider allowing financially strong surplus lines companies to participate in depopulation programs.

This is -- this next item is quite important: Equivalent coverage to the private market. Current law now requires that Citizens offer coverage equivalent to that which is offered in the voluntary market. While

Citizens' policies certainly -- policies certainly need to be sufficient to meet mortgage requirements and adequately protect the principal structure, there may be opportunities to make Citizens less attractive through the types of coverage it provides to consumers who do have another offer.

The next item is the statutory limit on depopulation bonus. The current law limits takeout bonuses to $100 per policy, which is paid only if the insurer agrees to keep the policy for at least five years, and proof of keeping that policy is required in order to receive the $100 bonus.

In this regard there may be other opportunities to incentivize depopulation through an enhanced depopulation program. One possibility that we're currently looking at is actually designing or developing good blocks of business within the Citizens book that we can talk with the private or voluntary market about depopulation.

GOVERNOR SCOTT: So where is the requirement that you have to do equivalent to the private?

MR. WALLACE: I don't have the language with me, but I know we could get it for you.

GOVERNOR SCOTT: Okay. If you can get it to me.

MR. WALLACE: Yes.

GOVERNOR SCOTT: So you can't -- you can't provide something that's more restrictive.

MR. WALLACE: Excuse me. We can provide coverage that is less restrictive, but we always have to offer that which is readily available in the voluntary market. So, yes, we can provide a DP-1 policy, but we also have to offer an HO-3 policy.

GOVERNOR SCOTT: Okay. Yeah, if you'll get me that information.

MR. WALLACE: Be glad to do so.

Slide number 12, operational changes. From an operating standpoint, operational changes that may reduce growth. Implementation of more restrictive coverage. As indicated on the previous slide, Citizens is required to provide coverage equivalent to what is available in the private market. However, we have already taken steps to remove ancillary coverages that in some cases are no longer

readily available in the private market.

For example, we have eliminated coverage for screen enclosures, carports, certain detached structures, and now provide a maximum $10,000 sublimit to provide coverage for damage to floors. In addition we --

GOVERNOR SCOTT: Excuse me just a second. So on the -- it said effective 1/1/2012 and 2 -- okay. So these are effective in January and February next year.

MR. WALLACE: Correct.

GOVERNOR SCOTT: Okay. And does -- does the typical policy cover floors?

MR. WALLACE: Pardon me?

GOVERNOR SCOTT: A typical policy covers floors or it doesn't?

MR. WALLACE: Yes.

ATTORNEY GENERAL BONDI: Yes.

GOVERNOR SCOTT: It does?

MR. WALLACE: Yes. And often --

GOVERNOR SCOTT: -- been your experience?

ATTORNEY GENERAL BONDI: It's just they do. And I mean that's a tremendous expense if someone has damage are your floors. And now --

MR. WALLACE: Right.

ATTORNEY GENERAL BONDI: -- they're going to be exempt in 2012?

MR. WALLACE: Well, it will have a $10,000 --

ATTORNEY GENERAL BONDI: 10,000 --

MR. WALLACE: -- sublimit. Yes.

GOVERNOR SCOTT: Okay.

MR. WALLACE: Okay. In addition we have an operational team put together that is reviewing potential changes, some of which include elimination of liability coverage, endorsements that may further restrict standard policy language, different deductible requirements, and other ideas that would ensure that we are not providing above average or Cadillac type coverage. In addition, we are also reviewing our ability to phase out our builder's risk program.

GOVERNOR SCOTT: What's your timing on these things that you're considering?

MR. WALLACE: I would say early 2012. At the February board meeting we will probably be presenting options for phasing out the builder's risk program. But once again this is something that has been talked to with only

several board members, and it has to go through the board of governors.

Also the adoption of new programs to motivate insurers to remove policies. Examples of incentives we currently are working on, again, packaging blocks of business for removal of Citizens to streamline and encourage depopulation. We are also looking into the -- revising the seating commission structures surrounding depopulation.

And the final -- the final point is on increasing -- increase market awareness and the use of FMAP. We are exploring ways to encourage the use of the Florida Market Assistance Plan to insure business that can be placed in the private sector does not end up in Citizens.

Initial thoughts on this were public service announcement, agent trade shows, and greater awareness wherever possible to the public to let them know that they do have options, they can contact FMAP. And what FMAP will do is shop the market or post the information on a readily available Web site. If an agent or insurance company is interested

in taking that risk outside of Citizens, it goes to that carrier and the agent and not to Citizens. That is the principal behind FMAP.

Okay. If we can go to slide 13 --

GOVERNOR SCOTT: Scott, can I ask you a question?

MR. WALLACE: Sure.

GOVERNOR SCOTT: What's the 16-percent ceding commission? What is it and what's the purpose of it?

MR. WALLACE: The 16-percent commission is basically money paid by the takeout company to pay up front agent commissions, and for Citizens to continue servicing the policy until its expiration. We would -- you know, when a policy is removed, we will continue servicing that policy until it comes up for renewal.

GOVERNOR SCOTT: And -- okay.

MR. WALLACE: So we --

GOVERNOR SCOTT: Is it mandatory?

MR. WALLACE: Well, it is now. But we are looking at different options within that. I mean, those are the two biggest drivers behind the ceding commission.

GOVERNOR SCOTT: Okay. So does it give an

incentive for people to move or not move?

MR. WALLACE: Well, I think, it would -- it would certainly give the companies greater incentive to take the business if they had a lower ceding commission to pay.

GOVERNOR SCOTT: And why wouldn't you have a lower one?

MR. WALLACE: Well, if we could justify being able to do our business and making sure that the agent gets paid, and -- at a reduced amount, that's the thing that we're exploring. And we still have expenses ourselves of servicing the account.

GOVERNOR SCOTT: But the bigger risk is having the policy.

MR. WALLACE: Yes. And depopulating our policy.

I think the important thing before we get to the last slide --

GOVERNOR SCOTT: Uh-huh.

MR. WALLACE: -- we are taking an approach -- and I know that Chairman Carlos Lacosta is way -- shouldn't use that language -- is very much behind our efforts and encouraging us to look at all opportunities in

which to refine Citizens and move it to a company of last resort.

There are some things that we can do and we will be doing, and we will be taking it up to the board on a periodic basis. What would be most helpful in this whole process, and I don't know the legislative will, but if we could get some other headway from the legislative standpoint to clear the way and set maybe a longer term direction designed to stand the test of time to provide a more stable long-term marketplace in the State of Florida.

GOVERNOR SCOTT: So, Scott, has anybody in the last few years come by and just said, I'll buy the whole company?

MR. WALLACE: No.

GOVERNOR SCOTT: Okay. So if -- would you recommend anybody to buy it?

MR. WALLACE: That's a very good question, because when I look at these numbers and the PLA, and especially the PLA, it seems to be able to stand pretty well given the -- I mean, we don't have to dive into many of the assessments on some pretty severe losses. I mean, you don't have emergency assessments on

some very large losses.

It really depends. Because what you really have is some very, very difficult economic times. I venture to guess in -- if it were five years ago, there may have been a couple of companies willing to take a big chunk of say the PLA business, which quite frankly did happen in 2008, we had 385,000 policies depopulated in that year.

GOVERNOR SCOTT: So if we just put Citizens out on the market for sale, do you have any idea if anybody would buy it right now, or how much it would -- let's say we were willing to write a check to get it off our books, do you think -- you know, where we didn't take any risk any more.

MR. WALLACE: I think in today's situation, it would require a check from us or the state to be the incentive to move that business at this point in time.

GOVERNOR SCOTT: How much do you think it would be?

MR. WALLACE: I don't have the figure on that but we could work on one.

GOVERNOR SCOTT: How would you come up

with it? What would be the analysis?

MR. WALLACE: Well, I think what has to happen, I would look at it similar to a private insurance company where how much surplus do you have, how much ability do you have to purchase reinsurance that would take you up to a one in 100-year event, and then have reoccurring events covered by going sideways on a couple of events, and still be able to weather the daily storms of non-Cat claims.

GOVERNOR SCOTT: Right.

MR. WALLACE: Citizens right now, we project in 2012 receiving 70,000 non-Cat claims. So it's...

GOVERNOR SCOTT: I would like to see that analysis.

MR. WALLACE: Okay. All right. If we can, we'll move to the final slide on --

GOVERNOR SCOTT: Yeah.

MR. WALLACE: -- status of key implementation provisions for Senate Bill 408.

Since Senate Bill 408 was signed in May, implementing the provisions of 408 has been a high priority for Citizens. As such, we have made necessary form and rate filings with the

Office of Insurance Regulation which will be implemented beginning in January 2012.

This also includes -- this also includes an assessment form that will also be attached and implemented to policies beginning in January with the new form.

I would also like to note that the sinkhole inspection program has been implemented. This program requires sinkhole inspections prior to binding coverage in the sinkhole prone territories.

And finally, within Senate Bill 408 we -- Citizens was required to do an outside analysis to determine and evaluate outsourcing opportunities. And that is well underway and will probably be sent out after board approval this coming November at the board meeting.

GOVERNOR SCOTT: Scott, do you -- I guess you guys went through your rate filing and you got a rate. Do you -- what's your belief as far as whether it's actuarially sound or not, for sinkhole?

MR. WALLACE: Well, let's do it this way: we had outside people from Milliman, from an economic view; we had people from outside

actuaries; we had internal actuarially staff -- actuarial staff; we also had another outside actuary, John Rollins, they all went through our information, and they understood the methodology behind it, they agreed with everything, they agreed with the results.

And quite frankly, my understanding is we have made a request from the OIR as to why there is such a large difference in what was filed versus what was actually approved, and to this point we have not received anything. And I think that -- once we do receive that information, that may be helpful.

GOVERNOR SCOTT: So when will you find out?

MR. WALLACE: Well, when the OIR gives it to us. I mean, we have not been given a date.

GOVERNOR SCOTT: But the law is the rates are supposed to be actuarially sound, right?

MR. WALLACE: Yes.

GOVERNOR SCOTT: Okay. All right.

MR. WALLACE: And we believe our filing was.

GOVERNOR SCOTT: All right. Any other -- I've got a comment, but does anybody else have

anything?

ATTORNEY GENERAL BONDI: No.

GOVERNOR SCOTT: Okay.

UNIDENTIFIED SPEAKER: (Inaudible.)

GOVERNOR SCOTT: Yeah. All right. First off, Scott, thanks for doing this. So the -- so the CFO, Speaker of the House, Senate President, and I have two appointments each to the Citizens board. We've each filled these appointments with qualified, experienced individuals.

For example, I appointed John Rollins, an actuary with over eight decades experience in the insurance industry, including a period of time at Citizens.

I also appointed John Workman who has over 20 years in the industry and has run several insurance companies.

The CFO appointed Carlos Lacosta, the chair of the Citizens board who was a member of the legislature when Citizens was created and who has extensive experience with property insurance issues in our state.

We made those appointments to find a solution to this problem. We know Citizens is

vulnerable, we saw that today as we go through the numbers. We know we have a serious problem if a major storm hits our state. We have to have real solutions, and I, along with everybody else up here, we expect the Citizens board to find them.

To that end, I would ask you and your staff to present the information discussed today to the Citizens board at their November 16 meeting. I would also like to ask you to poll the board members prior to the board meeting for their suggested solutions, and discuss each suggestion at the meeting.

I would also like the board to adopt a specific goal to reduce the size and exposure of Citizens. This is not sustainable.

And after examining the issues and concerning the consequences, I would expect the board to decide upon a plan of action to accomplish that goal. And I expect the board to present real solutions to me and the Cabinet at our December 6th meeting.

Finally, this is something we cannot continue to do. I expect the solution you and the board bring to me will solve the problem by

June of next year before the next hurricane season.

Thank you very much for your presentation today. Bye-bye.

MR. WALLACE: Thank you.

T H E C A B I N E T

S T A T E O F F L O R I D A

Representing:

CITIZENS PROPERTY INSURANCE CORPORATION BOARD REPORT

DEPARTMENT OF REVENUE

FINANCIAL SERVICES COMMISSION, OFFICE OF INSURANCE REGULATION

BOARD OF ADMINISTRATION, DEBT AFFORDABILITY REPORT PRESENTATION

BOARD OF ADMINISTRATION, DIVISION OF BOND FINANCE

BOARD OF TRUSTEES, INTERNAL IMPROVEMENT TRUST FUND

DEPARTMENT OF VETERANS' AFFAIRS

The above agencies came to be heard before THE FLORIDA CABINET, Honorable Governor Scott presiding, in the Cabinet Meeting Room, LL-03, The Capitol, Tallahassee, Florida, on December 6, 2011, commencing at 9:37 a.m.

Reported by:
CAROLYN L. RANKINE
Registered Professional Reporter
Notary Public

ACCURATE STENOTYPE REPORTERS, INC.
2894 REMINGTON GREEN LANE
TALLAHASSEE, FLORIDA 32308
850.878.2221

GOVERNOR SCOTT: Next is the Office of Insurance Regulation agenda presented by Kevin McCarty. Good morning, Kevin.

MR. McCARTY: Good morning, Governor, members of the Commission. I have three rules for your consideration today. The first rule is request for publication of repeal of the arbitration rule. The legislature had authorized the office to establish arbitration rules but they have subsequently eliminated that authority. This simply removes those from the code.

GOVERNOR SCOTT: Is there a motion to approve Item 1?

CFO ATWATER: So move.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Moved and seconded, show Item 1 approved without objection.

MR. McCARTY: The next agenda item is request for approval of publication of amendments to our auto manufacturing warranty rules. The legislature enacted a streamlined process to eliminate some of the requirements for issuing a certificate, which means large

automobile companies who own their own warranty companies would have a streamlined process for having a license in Florida. This incorporates those changes in our process.

GOVERNOR SCOTT: Okay. Is there a motion to approve Item 2?

ATTORNEY GENERAL BONDI: Move to approve.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Moved and seconded, Item 2 is approved without objection.

MR. McCARTY: And the last item is a request for final adoption as to proposed changes to our uniform mitigation verification inspection form. And just by way of contents, the legislature enacted provisions for providing consumers with discounts and credits if they provided certain mitigations to their homes: Reinforce their roofs, put in new windows, put in shutters.

And an unfortunate consequence of that was a proliferation of fraud and abuse. And we had tens of thousands of fraudulent claims that were put in for mitigations and discounts. And in the process, the legislature changed that,

modified it, made some technical corrections. In the process of four public hearings, we took testimony in the ways that we can button down so that we ensure the dual public purpose: One is to ensure consumers are getting the benefit of their credits by making sure that insurance companies are getting the proper premium for their policyholders.

ATTORNEY GENERAL BONDI: And, Governor, this also adds criminal penalties to protect the consumers which is very important.

MR. McCARTY: Yes. And the form was revised to incorporate the new penalties for fraud and abuse.

GOVERNOR SCOTT: All right. Is there a motion to approve Item 3?

ATTORNEY GENERAL BONDI: Move to approve.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Moved and seconded, Item 3 is approved without objection. Anything else?

MR. McCARTY: Thank you, Governor.

GOVERNOR SCOTT: Thank you very much. I know you're just as focused as we are in making

sure we get Citizens in the right position to where it doesn't cause us significant financial problems --

MR. McCARTY: We look --

GOVERNOR SCOTT: -- so thank you very much.

MR. McCARTY: We look forward to working with the chairman and the members of the Board in looking at ways for us to reduce the exposure to policyholders.

GOVERNOR SCOTT: Okay. Thanks, Kevin.

MR. McCARTY: Thank you.

GOVERNOR SCOTT: Have a good day.

M E M O R A N D U M

DATE: June 7, 2012

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Bob Prentiss

SUBJECT: Cabinet Agenda for June 26, 2012
Request for Approval to Publish Amendments to
Rules 69O-138.001; NAIC Financial Condition Examiners Handbook Adopted
69O-137.001; Annual and Quarterly Reporting Requirements

The Office of Insurance Regulation requests that these proposed rule amendment be presented to the Cabinet aides on or before June 20, 2012 and to the Financial Services Commission on June 26, 2012, with a request to approve for publication the proposed rules.

These rules are being amended to adopt the current versions of the National Association of Insurance Commissioners instructions, manuals and Financial Condition Handbook.

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

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

Approved for signature:

_____
Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

_____
Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-137.001 Annual and Quarterly Reporting Requirements.

(1) through (3) 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, 20112010;

2. The NAIC's Annual Statement Instructions, Life, Accident and Health, 20112010;

3. The NAIC's Annual Statement Instructions, Health, 20112010;

4. The NAIC's Annual Statement Instructions, Title, 20112010; and

5. The NAIC's Accounting Practices and Procedures Manual, as of March 20112010.

(b) and (c) no change

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

69O-138.001 NAIC Financial Condition Examiners Handbook Adopted.

(1)(a) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 20122~~2011~~is hereby adopted and incorporated by reference.

(2) – (3) No change.

Rulemaking ~~Specific~~ 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,_____.

624.308 Rules.--

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

624.424 Annual statement and other information.--

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

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

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

624.308 Rules.--

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

624.316 Examination of insurers.--

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

M E M O R A N D U M

DATE: April 18, 2012

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Bob Prentiss

SUBJECT: Cabinet Agenda for June 26, 2012
Request for Approval to Publish Amendments to
Rule 69O-149.003; Rate Filing Procedures
Assignment. # 123776-12

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before June 20, 2012 and to the Financial Services Commission on June 26, 2012, with a request to approve for publication the proposed rules.

Pursuant to Section 627.410(6)(a), Florida Statutes, health insurers seeking to issue or renew health insurance policy forms in the State of Florida must submit documentation (rating manuals, rating schedules, change in rating manual, change in rating schedule, etc) to the Office demonstrating that the proposed policy or policy renewal's premium rates are reasonable in relation to the benefits provided. Rule 69O-149.003, Florida Administrative Code, provides insurers with detailed rate filing procedures.

Rule 69O-149.003(5), Florida Administrative Code, allows insurers without fully credible data to make streamlined rate increase filings with the Office that are simpler in format and content than the full filing format defined in Rule 69O-149.003(2), Florida Administrative Code. Insurers who qualify and elect to file streamlined rate increase filings with the Office are limited to rate increases equal to the maximum annual medical trend for medical expense coverage or the maximum annual medical trend for Medicare Supplement coverage.

The current version of Rule 69O-149.003(6), Florida Administrative Code, includes tables which display the applicable maximum annual medical trend. The proposed amendments to Rule 69O-149.003 delete the maximum annual medical trend tables from the text of the rule and provides the URL of the Office's website on which the Office will publish and update the tables as needed.

Rule 69O-149.003(5)(a), Florida Administrative Code, defines the qualifications that insurers must meet to make streamlined rate increase filings. The current version of 69O-149.003(5)(a) allows Medicare Supplement providers with fewer than 1,000 Florida policyholders to make streamlined rate increase filings with the Office. The proposed amendments to 69O-149.003(5)(a) limit the use of streamlined rate increase filings to Medicare Supplement providers with fewer than 1,000 policyholders nationwide rather than to 1,000 policyholders in Florida.

Sections 624.308(1), 624.424(1)(c), 627.410(6)(b),(e), 119.07(1)(b), 624.307(1), 626.9541(1),627.410, FS.,provide rulemaking authority and laws implemented for this rule.

JBN

Jason Nelson 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:

Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-149.003 Rate Filing Procedures.

(1) – (2) – No Changes.

(3) Filings shall be submitted electronically to https://iportal.fldfs.com/.

(4) No Changes.

(5)(a) Insurers with fewer than 1,000 Florida policyholders, under medical expense forms with coverage meeting the definition of Section 627.6561(5)(a)2., F.S., or any form or pooled group of Medicare supplement forms with fewer than 1,000 Nationwide policyholders, ~~or medical expense forms with coverage meeting the definition of Section 627.6561(5)(a)2., F.S.,~~ may, at their option, file a streamlined rate increase filing where the annualized rate increase does not exceed~~ing~~ annual medical trend as provided in subsection (6) below.

(b) –(f) No changes.

(6)(a) The ~~following~~ tables found at www.floir.com shall apply to filings made pursuant to subsection (5) above. They contain the maximum medical trend for medical expense coverage described in Section 627.6561(5)(a)2,F.S. and the maximum medical trend for Medicare Supplement coverage.

(b) A company without fully credible data may, at its option, use an annual medical trend assumption not to exceed the values in the ~~following~~ tables referenced in (a) for the medical trend assumption used in a complete filing made pursuant to paragraph 69O-149.003(2)(b), F.A.C., including the actuarial memorandum required by Rule 69O-149.006, F.A.C., without providing explicit trend justification.

(c) Use of an annual medical trend assumption exceeding the maximum medical trend in the ~~following~~ tables referenced in (a) shall be filed pursuant to subparagraph 69O-149.006(3)(b)18., F.A.C.

~~(d) The maximum medical trend for medical expense coverage described in Section 627.6561(5)(a)2., F.S., is:~~

~~Category~~	~~Individual Without Rx~~	~~Individual With Rx~~	~~Group Without Rx~~	~~Group With Rx~~
~~Major Medical~~	~~11.5%~~	~~12.0%~~	~~13.0%~~	~~13.5%~~
~~Health Maintenance Organizations~~	~~10.5%~~	~~11.0%~~	~~13.0%~~	~~13.5%~~

~~(e) The maximum medical trend for Medicare supplement coverage is:~~

~~Medicare supplement~~	~~5.5%~~	~~10%~~	~~5.5%~~	~~10%~~

Specific Authority 624.308(1), 624,424(1)(c), 627.410(6)(b), (e) FS. Law Implemented 119.07(1)(b), 624.307(1), 626.9541(1), 627.410 FS. History–New 7-1-85, Formerly 4-58.03, 4-58.003, Amended 8-23-93, 4-18-94, 8-22-95, 4-4-02, 10-27-02, 6-19-03, Formerly 4-149.003, Amended 5-18-04, 12-22-05, 1-16-08, 10-2-08.

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) (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.

627.410 Filing, approval of forms.—

(6) (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 shall be for informational purposes.

(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 shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.

1. An insurer may discontinue the availability of a policy form if the insurer provides to the office in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer shall no longer offer for sale the policy form or certificate form in this state.

2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. shall not file for approval a new policy form providing similar benefits as the discontinued form for a period of 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.

3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes.

119.07 Inspection and copying of records; photographing public records; fees; exemptions.—

(1) (b) A custodian of public records or a person having custody of public records may designate another officer or employee of the agency to permit the inspection and copying of public records, but must disclose the identity of the designee to the person requesting to inspect or copy public records.

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:

(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, or comparison 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.

(b) False information and advertising generally.—Knowingly 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:

1. In a newspaper, magazine, or other publication,
2. In the form of a notice, circular, pamphlet, letter, or poster,
3. Over any radio or television station, or
4. In any other way,

an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, which is untrue, deceptive, or misleading.

(c) Defamation.—Knowingly making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of, any oral or written statement, or any pamphlet, circular, article, or literature, which is false or maliciously critical of, or derogatory to, any person and which is calculated to injure such person.

(d) Boycott, coercion, and intimidation.—Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in, or tending to result in, unreasonable restraint of, or monopoly in, the business of insurance.

(e) False statements and entries.—

1. Knowingly:

a. Filing with any supervisory or other public official,
b. Making, publishing, disseminating, circulating,
c. Delivering to any person,
d. Placing before the public,
e. Causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public,

any false material statement.

2. Knowingly making any false entry of a material fact in any book, report, or statement of any person, or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report, or statement of such person.

(f) Stock operations and advisory board contracts.—Issuing or delivering, promising to issue or deliver, or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns or profits as an inducement to insurance.

(g) Unfair discrimination.—

1. Knowingly making or permitting any unfair discrimination between individuals of the same actuarially supportable class and equal expectation of life, in the rates charged for any life insurance or annuity contract, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

2. Knowingly making or permitting any unfair discrimination between individuals of the same actuarially supportable class, as determined at the original time of issuance of the coverage, and essentially the same hazard, in the amount of premium, policy fees, or rates charged for any policy or contract of accident, disability, or health insurance, in the benefits payable thereunder, in any of the terms or conditions of such contract, or in any other manner whatever.

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 shall 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 does not constitute an act of unfair discrimination as defined in this paragraph.

(h) Unlawful rebates.—

1. Except as otherwise expressly provided by law, or in an applicable filing with the office, knowingly:

a. Permitting, or offering to make, or making, any contract or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon;
b. Paying, allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance contract, any unlawful rebate of premiums payable on the

contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract;

c. Giving, selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance contract or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the insurance contract.

2. Nothing in paragraph (g) or subparagraph 1. of this paragraph shall be construed as including within the definition of discrimination or unlawful rebates:

a. In the case of any contract of life insurance or life annuity, paying bonuses to all policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided that any such bonuses or abatement of premiums is fair and equitable to all policyholders and for the best interests of the company and its policyholders.

b. In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses.

c. Readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

d. Issuance of life insurance policies or annuity contracts at rates less than the usual rates of premiums for such policies or contracts, as group insurance or employee insurance as defined in this code.

e. Issuing life or disability insurance policies on a salary savings, bank draft, preauthorized check, payroll deduction, or other similar plan at a reduced rate reasonably related to the savings made by the use of such plan.

3.a. No title insurer, or any member, employee, attorney, agent, or agency thereof, shall pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as inducement to title insurance, or after such insurance has been effected, any rebate or abatement of the premium or any other charge or fee, or provide any special favor or advantage, or any monetary consideration or inducement whatever.

b. Nothing in this subparagraph shall be construed as prohibiting the payment of fees to attorneys at law duly licensed to practice law in the courts of this state, for professional services, or as prohibiting the payment of earned portions of the premium to duly appointed agents or agencies who actually perform services for the title insurer. Nothing in this subparagraph shall be construed as prohibiting a rebate or abatement of an attorney's fee charged for professional services, or that portion of the premium that is not required to be retained by the insurer pursuant to s. 627.782(1), or any other agent charge or fee to the person responsible for paying the premium, charge, or fee.

c. No insured named in a policy, or any other person directly or indirectly connected with the transaction involving the issuance of such policy, including, but not limited to, any mortgage broker, real estate broker, builder, or attorney, any employee, agent, agency, or representative thereof, or any other person whatsoever, shall knowingly receive or accept, directly or indirectly, any rebate or abatement of any portion of the title insurance premium or of any other charge or fee or any monetary consideration or inducement whatsoever, except as set forth in sub-subparagraph b.; provided, in no event shall any portion of the attorney's fee, any portion of the premium that is not required to be retained by the insurer pursuant to s. 627.782(1), any agent charge or fee, or any other monetary consideration or inducement be paid directly or indirectly for the referral of title insurance business.

(i) Unfair claim settlement practices.—

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;

2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy; or

3. Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Failing to adopt and implement standards for the proper investigation of claims;

b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

c. Failing to acknowledge and act promptly upon communications with respect to claims;

d. Denying claims without conducting reasonable investigations based upon available information;

e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed;

f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;

g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or

h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

4. Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed.

(j) Failure to maintain complaint-handling procedures.—Failure of any person to maintain a complete record of all the complaints received since the date of the last examination. For purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance.

(k) Misrepresentation in insurance applications.—

1. Knowingly making a false or fraudulent written or oral statement or representation on, or relative to, an application or negotiation for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual.

2. Knowingly making a material omission in the comparison of a life, health, or Medicare supplement insurance replacement policy with the policy it replaces for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual. For the purposes of this subparagraph, a material omission includes the failure to advise the insured of the existence and operation of a preexisting condition clause in the replacement policy.

(l) Twisting.—Knowingly making any misleading representations or incomplete or fraudulent comparisons or fraudulent material omissions of or with respect to any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse,

forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance in another insurer.

(m) Advertising gifts permitted.—No provision of paragraph (f), paragraph (g), or paragraph (h) shall be deemed to prohibit a licensed insurer or its agent from giving to insureds, prospective insureds, and others, for the purpose of advertising, any article of merchandise having a value of not more than $25.

(n) Free insurance prohibited.—

1. Advertising, offering, or providing free insurance as an inducement to the purchase or sale of real or personal property or of services directly or indirectly connected with such real or personal property.

2. For the purposes of this paragraph, "free" insurance is:

a. Insurance for which no identifiable and additional charge is made to the purchaser of such real property, personal property, or services.

b. Insurance for which an identifiable or additional charge is made in an amount less than the cost of such insurance as to the seller or other person, other than the insurer, providing the same.

3. Subparagraphs 1. and 2. do not apply to:

a. Insurance of, loss of, or damage to the real or personal property involved in any such sale or services, under a policy covering the interests therein of the seller or vendor.

b. Blanket disability insurance as defined in s. 627.659.

c. Credit life insurance or credit disability insurance.

d. Any individual, isolated, nonrecurring unadvertised transaction not in the regular course of business.

e. Title insurance.

f. Any purchase agreement involving the purchase of a cemetery lot or lots in which, under stated conditions, any balance due is forgiven upon the death of the purchaser.

g. Life insurance, trip cancellation insurance, or lost baggage insurance offered by a travel agency as part of a travel package offered by and booked through the agency.

4. Using the word "free" or words which imply the provision of insurance without a cost to describe life or disability insurance, in connection with the advertising or offering for sale of any kind of goods, merchandise, or services.

(o) Illegal dealings in premiums; excess or reduced charges for insurance.—

1. Knowingly collecting any sum as a premium or charge for insurance, which is not then provided, or is not in due course to be provided, subject to acceptance of the risk by the insurer, by an insurance policy issued by an insurer as permitted by this code.

2. Knowingly collecting as a premium or charge for insurance any sum in excess of or less than the premium or charge applicable to such insurance, in accordance with the applicable classifications and rates as filed with and approved by the office, and as specified in the policy; or, in cases when classifications, premiums, or rates are not required by this code to be so filed and approved, premiums and charges collected from a Florida resident in excess of or less than those specified in the policy and as fixed by the insurer. This provision shall not be deemed to prohibit the charging and collection, by surplus lines agents licensed under part VIII of this chapter, of the amount of applicable state and federal taxes, or fees as authorized by s. 626.916(4), in addition to the premium required by the insurer or the charging and collection, by licensed agents, of the exact amount of any discount or other such fee charged by a credit card facility in connection with the use of a credit card, as authorized by subparagraph (q)3., in addition to the premium required by the insurer. This subparagraph shall not be construed to prohibit collection of a premium for a universal life or a variable or indeterminate value insurance policy made in accordance with the terms of the contract.

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.

b. An insurer which imposes and collects such a surcharge or which refuses to renew such policy shall, in conjunction with the notice of premium due or notice of nonrenewal, notify the named insured that he or she is entitled to reimbursement of such amount or renewal of the policy under the conditions listed below and will subsequently reimburse him or her or renew the policy, if the named insured demonstrates that the operator involved in the accident was:

(I) Lawfully parked;

(II) Reimbursed by, or on behalf of, a person responsible for the accident or has a judgment against such person;

(III) Struck in the rear by another vehicle headed in the same direction and was not convicted of a moving traffic violation in connection with the accident;

(IV) Hit by a "hit-and-run" driver, if the accident was reported to the proper authorities within 24 hours after discovering the accident;

(V) Not convicted of a moving traffic violation in connection with the accident, but the operator of the other automobile involved in such accident was convicted of a moving traffic violation;

(VI) Finally adjudicated not to be liable by a court of competent jurisdiction;

(VII) In receipt of a traffic citation which was dismissed or nolle prossed; or

(VIII) Not at fault as evidenced by a written statement from the insured establishing facts demonstrating lack of fault which are not rebutted by information in the insurer's file from which the insurer in good faith determines that the insured was substantially at fault.

c. In addition to the other provisions of this subparagraph, an insurer may not fail to renew a policy if the insured has had only one accident in which he or she was at fault within the current 3-year period. However, an insurer may nonrenew a policy for reasons other than accidents in accordance with s. 627.728. This subparagraph does not prohibit nonrenewal of a policy under which the insured has had three or more accidents, regardless of fault, during the most recent 3-year period.

4. Imposing or requesting an additional premium for, or refusing to renew, a policy for motor vehicle insurance solely because the insured committed a noncriminal traffic infraction as described in s. 318.14 unless the infraction is:

a. A second infraction committed within an 18-month period, or a third or subsequent infraction committed within a 36-month period.

b. A violation of s. 316.183, when such violation is a result of exceeding the lawful speed limit by more than 15 miles per hour.

5. Upon the request of the insured, the insurer and licensed agent shall supply to the insured the complete proof of fault or other criteria which justifies the additional charge or cancellation.

6. No insurer shall impose or request an additional premium for motor vehicle insurance, cancel or refuse to issue a policy, or refuse to renew a policy because the insured or the applicant is a handicapped or physically disabled person, so long as such handicap or physical disability does not substantially impair such person's mechanically assisted driving ability.

7. No insurer may cancel or otherwise terminate any insurance contract or coverage, or require execution of a consent to rate endorsement, during the stated policy term for the purpose of offering to issue, or issuing, a similar or identical contract or coverage to the same insured with the same exposure at a higher premium rate or continuing an existing contract or coverage with the same exposure at an increased premium.

8. No insurer may issue a nonrenewal notice on any insurance contract or coverage, or require execution of a consent to rate endorsement, for the purpose of offering to issue, or

issuing, a similar or identical contract or coverage to the same insured at a higher premium rate or continuing an existing contract or coverage at an increased premium without meeting any applicable notice requirements.

9. No insurer shall, with respect to premiums charged for motor vehicle insurance, unfairly discriminate solely on the basis of age, sex, marital status, or scholastic achievement.

10. Imposing or requesting an additional premium for motor vehicle comprehensive or uninsured motorist coverage solely because the insured was involved in a motor vehicle accident or was convicted of a moving traffic violation.

11. No insurer shall cancel or issue a nonrenewal notice on any insurance policy or contract without complying with any applicable cancellation or nonrenewal provision required under the Florida Insurance Code.

12. No insurer shall impose or request an additional premium, cancel a policy, or issue a nonrenewal notice on any insurance policy or contract because of any traffic infraction when adjudication has been withheld and no points have been assessed pursuant to s. 318.14(9) and (10). However, this subparagraph does not apply to traffic infractions involving accidents in which the insurer has incurred a loss due to the fault of the insured.

(p) Insurance cost specified in "price package".—

1. When the premium or charge for insurance of or involving such property or merchandise is included in the overall purchase price or financing of the purchase of merchandise or property, the vendor or lender shall separately state and identify the amount charged and to be paid for the insurance, and the classifications, if any, upon which based; and the inclusion or exclusion of the cost of insurance in such purchase price or financing shall not increase, reduce, or otherwise affect any other factor involved in the cost of the merchandise, property, or financing as to the purchaser or borrower.

2. This paragraph does not apply to transactions which are subject to the provisions of part I of chapter 520, entitled "The Motor Vehicle Sales Finance Act."

3. This paragraph does not apply to credit life or credit disability insurance which is in compliance with s. 627.681(4).

(q) Certain insurance transactions through credit card facilities prohibited.—

1. Except as provided in subparagraph 3., no person shall knowingly solicit or negotiate any insurance; seek or accept applications for insurance; issue or deliver any policy; receive, collect, or transmit premiums, to or for any insurer; or otherwise transact insurance in this state, or relative to a subject of insurance resident, located, or to be performed in this state, through the arrangement or facilities of a credit card facility or organization, for the purpose of insuring credit card holders or prospective credit card holders. The term "credit card holder" as used in this paragraph means any person who may pay the charge for purchases or other transactions through the credit card facility or organization, whose credit with such facility or organization is evidenced by a credit card identifying such person as being one whose charges the credit card facility or organization will pay, and who is identified as such upon the credit card either by name, account number, symbol, insignia, or any other method or device of identification. This subparagraph does not apply as to health insurance or to credit life, credit disability, or credit property insurance.

2. Whenever any person does or performs in this state any of the acts in violation of subparagraph 1. for or on behalf of any insurer or credit card facility, such insurer or credit card facility shall be held to be doing business in this state and, if an insurer, shall be subject to the same state, county, and municipal taxes as insurers that have been legally qualified and admitted to do business in this state by agents or otherwise are subject, the same to be assessed and collected against such insurers; and such person so doing or performing any of such acts shall be personally liable for all such taxes.

3. A licensed agent or insurer may solicit or negotiate any insurance; seek or accept applications for insurance; issue or deliver any policy; receive, collect, or transmit premiums, to or for any insurer; or otherwise transact insurance in this state, or relative to

a subject of insurance resident, located, or to be performed in this state, through the arrangement or facilities of a credit card facility or organization, for the purpose of insuring credit card holders or prospective credit card holders if:

a. The insurance or policy which is the subject of the transaction is noncancelable by any person other than the named insured, the policyholder, or the insurer;

b. Any refund of unearned premium is made directly to the credit card holder; and

c. The credit card transaction is authorized by the signature of the credit card holder or other person authorized to sign on the credit card account.

The conditions enumerated in sub-subparagraphs a.-c. do not apply to health insurance or to credit life, credit disability, or credit property insurance; and sub-subparagraph c. does not apply to property and casualty insurance so long as the transaction is authorized by the insured.

4. No person may use or disclose information resulting from the use of a credit card in conjunction with the purchase of insurance, when such information is to the advantage of such credit card facility or an insurance agent, or is to the detriment of the insured or any other insurance agent; except that this provision does not prohibit a credit card facility from using or disclosing such information in any judicial proceeding or consistent with applicable law on credit reporting.

5. No such insurance shall be sold through a credit card facility in conjunction with membership in any 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, the definition of automobile clubs 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 race courses established and marked as such for the duration of such particular event. The words "motor vehicle" used herein shall be the same as defined in chapter 320.

(r) Interlocking ownership and management.—

1. Any domestic insurer may retain, invest in, or acquire the whole or any part of the capital stock of any other insurer or insurers, or have a common management with any other insurer or insurers, unless such retention, investment, acquisition, or common management is inconsistent with any other provision of this code, or unless by reason thereof the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business.

2. Any person otherwise qualified may be a director of two or more domestic insurers which are competitors, unless the effect thereof is substantially to lessen competition between insurers generally or materially tend to create a monopoly.

3. Any limitation contained in this paragraph does not apply to any person who is a director of two or more insurers under common control or management.

(s) Prohibited arrangements as to funerals.—

1. No life insurer shall designate in any life insurance policy the person to conduct the funeral of the insured, or organize, promote, or operate any enterprise or plan to enter into any contract with any insured under which the freedom of choice in the open market of the person having the legal right to such choice is restricted as to the purchase, arrangement, and conduct of a funeral service or any part thereof for any individual insured by the insurer. No life insurer shall designate in any life insurance policy the person to conduct the funeral of the insured as the owner of the policy.

2. No insurer shall contract or agree to furnish funeral merchandise or services in connection with the disposition of any person upon the death of any person insured by such insurer.

3. No insurer shall contract or agree with any funeral director or direct disposer to the effect that such funeral director or direct disposer shall conduct the funeral of any person insured by such insurer.

4. No insurer shall provide, in any insurance contract covering the life of any person in this state, for the payment of the proceeds or benefits thereof in other than legal tender of the United States and of this state, or for the withholding of such proceeds or benefits, all for the purpose of either directly or indirectly providing, inducing, or furthering any arrangement or agreement designed to require or induce the employment of a particular person to conduct the funeral of the insured.

(t) Certain life insurance relations with funeral directors prohibited.—

1. No life insurer shall permit any funeral director or direct disposer to act as its representative, adjuster, claim agent, special claim agent, or agent for such insurer in soliciting, negotiating, or effecting contracts of life insurance on any plan or of any nature issued by such insurer or in collecting premiums for holders of any such contracts except as prescribed in s. 626.785(3).

2. No life insurer shall:

a. Affix, or permit to be affixed, advertising matter of any kind or character of any licensed funeral director or direct disposer to such policies of insurance.

b. Circulate, or permit to be circulated, any such advertising matter with such insurance policies.

c. Attempt in any manner or form to influence policyholders of the insurer to employ the services of any particular licensed funeral director or direct disposer.

3. No such insurer shall maintain, or permit its agent to maintain, an office or place of business in the office, establishment, or place of business of any funeral director or direct disposer in this state.

(u) False claims; obtaining or retaining money dishonestly.—

1. Any agent, physician, claimant, or other person who causes to be presented to any insurer a false claim for payment, knowing the same to be false; or

2. Any agent, collector, or other person who represents any insurer or collects or does business without the authority of the insurer, secures cash advances by false statements, or fails to turn over when required, or satisfactorily account for, all collections of such insurer,

shall, in addition to the other penalties provided in this act, be guilty of a misdemeanor of the second degree and, upon conviction thereof, shall be subject to the penalties provided by s. 775.082 or s. 775.083.

(v) Proposal required.—If a person simultaneously holds a securities license and a life insurance license, he or she shall prepare and leave with each prospective buyer a written proposal, on or before delivery of any investment plan. "Investment plan" means a mutual funds program, and the proposal shall consist of a prospectus describing the investment feature and a full illustration of any life insurance feature. The proposal shall be prepared in duplicate, dated, and signed by the licensee. The original shall be left with the prospect, the duplicate shall be retained by the licensee for a period of not less than 3 years, and a copy shall be furnished to the department upon its request. In lieu of a duplicate copy, a receipt for standardized proposals filed with the department may be obtained and held by the licensee.

(w) Soliciting or accepting new or renewal insurance risks by insolvent or impaired insurer prohibited; penalty.—

1. Whether or not delinquency proceedings as to the insurer have been or are to be initiated, but while such insolvency or impairment exists, no director or officer of an insurer, except with the written permission of the office, shall authorize or permit the insurer to solicit or accept new or renewal insurance risks in this state after such director or officer

knew, or reasonably should have known, that the insurer was insolvent or impaired. "Impaired" includes impairment of capital or surplus, as defined in s. 631.011(12) and (13).

2. Any such director or officer, upon conviction of a violation of this paragraph, is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(x) Refusal to insure.—In addition to other provisions of this code, the refusal to insure, or continue to insure, any individual or risk solely because of:

1. Race, color, creed, marital status, sex, or national origin;

2. The residence, age, or lawful occupation of the individual or the location of the risk, unless there is a reasonable relationship between the residence, age, or lawful occupation of the individual or the location of the risk and the coverage issued or to be issued;

3. The insured's or applicant's failure to agree to place collateral business with any insurer, unless the coverage applied for would provide liability coverage which is excess over that provided in policies maintained on property or motor vehicles;

4. The insured's or applicant's failure to purchase noninsurance services or commodities, including automobile services as defined in s. 624.124;

5. The fact that the insured or applicant is a public official; or

6. The fact that the insured or applicant had been previously refused insurance coverage by any insurer, when such refusal to insure or continue to insure for this reason occurs with such frequency as to indicate a general business practice.

(y) Powers of attorney.—Except as provided in s. 627.842(2):

1. Requiring, as a condition to the purchase or continuation of an insurance policy, that an applicant for insurance or an insured execute a power of attorney in favor of an insurance agent or agency or employee thereof; or

2. Presenting to the applicant or the insured, as a routine business practice, a form that authorizes the insurance agent or agency to sign the applicant's or insured's name on any insurance-related document or application for the purchase of motor vehicle services as described in s. 624.124. To be valid, a power of attorney must be an act or practice other than as described in this paragraph, must be a separate writing in a separate document, must be executed with the full knowledge and consent of the applicant or insured who grants the power of attorney, must be in the best interests of the insured or applicant, and a copy of the power of attorney must be provided to the applicant or insured at the time of the transaction.

(z) Sliding.—Sliding is the act or practice of:

1. Representing to the applicant that a specific ancillary coverage or product is required by law in conjunction with the purchase of insurance when such coverage or product is not required;

2. Representing to the applicant that a specific ancillary coverage or product is included in the policy applied for without an additional charge when such charge is required; or

3. Charging an applicant for a specific ancillary coverage or product, in addition to the cost of the insurance coverage applied for, without the informed consent of the applicant.

[1](aa) Churning.—

1. Churning is the practice whereby policy values in an existing life insurance policy or annuity contract, including, but not limited to, cash, loan values, or dividend values, and in any riders to that policy or contract, are directly or indirectly used to purchase another insurance policy or annuity contract with that same insurer for the purpose of earning additional premiums, fees, commissions, or other compensation:

a. Without an objectively reasonable basis for believing that the replacement or extraction will result in an actual and demonstrable benefit to the policyholder;

b. In a fashion that is fraudulent, deceptive, or otherwise misleading or that involves a deceptive omission;

c. When the applicant is not informed that the policy values including cash values, dividends, and other assets of the existing policy or contract will be reduced, forfeited, or used in the purchase of the replacing or additional policy or contract, if this is the case; or
d. Without informing the applicant that the replacing or additional policy or contract will not be a paid-up policy or that additional premiums will be due, if this is the case.

Churning by an insurer or an agent is an unfair method of competition and an unfair or deceptive act or practice.

2. Each insurer shall comply with sub-subparagraphs 1.c. and 1.d. by disclosing to the applicant at the time of the offer on a form designed and adopted by rule by the commission if, how, and the extent to which the policy or contract values (including cash value, dividends, and other assets) of a previously issued policy or contract will be used to purchase a replacing or additional policy or contract with the same insurer. The form must include disclosure of the premium, the death benefit of the proposed replacing or additional policy, and the date when the policy values of the existing policy or contract will be insufficient to pay the premiums of the replacing or additional policy or contract.
3. Each insurer shall adopt written procedures to reasonably avoid churning of policies or contracts that it has issued, and failure to adopt written procedures sufficient to reasonably avoid churning shall be an unfair method of competition and an unfair or deceptive act or practice.
(bb) Deceptive use of name.—Using the name or logo of a financial institution, as defined in s. 655.005(1), or its affiliates or subsidiaries when marketing or soliciting existing or prospective customers if such marketing materials are used without the written consent of the financial institution and in a manner that would lead a reasonable person to believe that the material or solicitation originated from, was endorsed by, or is related to or the responsibility of the financial institution or its affiliates or subsidiaries.
(cc) Unfair rate increases for persons in military service.—Charging an increased premium for reinstating a motor vehicle insurance policy that was canceled or suspended by the insured solely for the reason that he or she was transferred out of this state while serving in the United States Armed Forces or on active duty in the National Guard or United States Armed Forces Reserve. It is also an unfair practice for an insurer to charge an increased premium for a new motor vehicle insurance policy if the applicant for coverage or his or her covered dependents were previously insured with a different insurer and canceled that policy solely for the reason that he or she was transferred out of this state while serving in the United States Armed Forces or on active duty in the National Guard or United States Armed Forces Reserve. For purposes of determining premiums, an insurer shall consider such persons as having maintained continuous coverage.
(dd) Life insurance limitations based on past foreign travel experiences or future foreign travel plans.—
1. An insurer may not refuse life insurance to; refuse to continue the life insurance of; or limit the amount, extent, or kind of life insurance coverage available to an individual based solely on the individual's past lawful foreign travel experiences.
2. An insurer may not refuse life insurance to; refuse to continue the life insurance of; or limit the amount, extent, or kind of life insurance coverage available to an individual based solely on the individual's future lawful travel plans unless the insurer can demonstrate and the Office of Insurance Regulation determines that:
a. Individuals who travel are a separate actuarially supportable class whose risk of loss is different from those individuals who do not travel; and
b. Such risk classification is based upon sound actuarial principles and actual or reasonably anticipated experience that correlates to the risk of travel to a specific destination.

3. The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 necessary to implement this paragraph and may provide for limited exceptions that are based upon national or international emergency conditions that affect the public health, safety, and welfare and that are consistent with public policy.

4. Each market conduct examination of a life insurer conducted pursuant to s. 624.3161 shall include a review of every application under which such insurer refused to issue life insurance; refused to continue life insurance; or limited the amount, extent, or kind of life insurance issued, based upon future lawful travel plans.

5. The administrative fines provided in s. 624.4211(2) and (3) shall be trebled for violations of this paragraph.

6. The Office of Insurance Regulation shall report to the President of the Senate and the Speaker of the House of Representatives by March 1, 2007, and on the same date annually thereafter, on the implementation of this paragraph. The report shall include, but not be limited to, the number of applications under which life insurance was denied, continuance was refused, or coverage was limited based on future travel plans; the number of insurers taking such action; and the reason for taking each such action.

[1](ee) Fraudulent signatures on an application or policy-related document.—Willfully submitting to an insurer on behalf of a consumer an insurance application or policy-related document bearing a false or fraudulent signature.

[1](ff) Unlawful use of designations; misrepresentation of agent qualifications.—

1. A licensee may not, in any sales presentation or solicitation for insurance, use a designation or title in such a way as to falsely imply that the licensee:

a. Possesses special financial knowledge or has obtained specialized financial training; or

b. Is certified or qualified to provide specialized financial advice to senior citizens.

2. A licensee may not use terms such as "financial advisor" in such a way as to falsely imply that the licensee is licensed or qualified to discuss, sell, or recommend financial products other than insurance products.

3. A licensee may not, in any sales presentation or solicitation for insurance, falsely imply that he or she is qualified to discuss, recommend, or sell securities or other investment products in addition to insurance products.

4. A licensee who also holds a designation as a certified financial planner (CFP), chartered life underwriter (CLU), chartered financial consultant (ChFC), life underwriter training council fellow (LUTC), or the appropriate license to sell securities from the Financial Industry Regulatory Authority (FINRA) may inform the customer of those licenses or designations and make recommendations in accordance with those licenses or designations, and in so doing does not violate this paragraph.

627.410 Filing, approval of forms.—

(1) No 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, or group certificates issued under a master contract delivered in this state, or printed rider or endorsement form or form of renewal certificate, shall be delivered or issued for delivery in this state, unless the form has been filed with the office by or in behalf of the insurer which proposes to use such form and has been approved by the office. This provision does not apply to surety bonds or to policies, riders, endorsements, or forms of unique character which are designed for and used with relation to insurance upon a particular subject (other than as to health insurance), or which relate to the manner of distribution of 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. As to 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 not less than 30 days in advance of any such use or delivery. At the expiration of such 30 days, the form so filed will be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the office. The approval of any such form 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 form, 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 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 shall not deliver or 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 shall be for informational purposes.

(c) Every filing made pursuant to this subsection shall be made within the same time period provided in, and shall be deemed to be approved under the same conditions as those provided in, subsection (2).

(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, shall be prohibited from applying the following rating practices:

1. Select and ultimate premium schedules.
2. Premium class definitions which 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 shall

not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.

1. An insurer may discontinue the availability of a policy form if the insurer provides to the office in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer shall no longer offer for sale the policy form or certificate form in this state.
2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. shall not file for approval a new policy form providing similar benefits as the discontinued form for a period of 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.
3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes.

(7)(a) Each insurer subject to the requirements of subsection (6) shall make an annual filing with the office no later than 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. 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.

(b) The filing required by this subsection 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 promulgated by the commission.
2. If no rate change is proposed, a filing which 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.

(c) As used in this section, "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 with 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.

(d) 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.

(e) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days following 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.

M E M O R A N D U M

DATE: June 5, 2012

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill DKT
Jason Nelson JN

SUBJECT: Cabinet Agenda for June 26, 2012
Request for Approval to Publish Amendments to
Rule 69O-149.022; Forms Adopted
Assignment # 124691-12

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before June 20, 2012 and to the Financial Services Commission on June 26, 2012, with a request to approve for publication the proposed rule amendments.

The purpose of this rule is to update and edit the contents of the Universal Standardized Data Letter (UDL) form and instructions used by Life and Health insurers to make electronic form filings via the Office's I-File system. The proposed revisions simplify the reporting entries to reflect the Office's technology. Most of the proposed changes are already in place and have been filed by insurers for some time. As a result, the adoption of these changes by rule will not have a significant economic impact on the insurers that are required to file the revised form.

Sections 624.308, 624.424(1)(c), 627.410, 636.216, 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:

_____
Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

_____
Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-149.022 Forms Adopted.

(1) The forms adopted in subsection (2), below, shall be used, as applicable, by insurers making form filings for life and accident insurance, annuities, and health insurance. All the forms in subsection (2), below, are hereby adopted and incorporated by reference. All forms are available and may be printed from the Office's website: www.floir.com.

(2)(a) Form OIR-B2-1507, "Office of Insurance Regulation, Life and Health Forms and Rates Universal Standardized Data Letter", Rev. ~~9/04~~ 06/12.

(b) Form OIR-B2-1507 A, "Office of Insurance Regulation, Life and Health Forms and Rates Universal Standardized Data Letter Instruction Sheet", Rev. ~~9/04~~ 06/12.

(c) Health Checklists.

1. OIR-B2-1616, "Blanket Application Checklist", Rev. 1/05.
2. OIR-B2-535, "Blanket Health Contract Checklist", Rev. 1/04.
3. OIR-B2-527, "Debtor Group Application Checklist", Rev. 1/04.
4. OIR-B2-529, "Debtor Group Contract Checklist", Rev. 1/04.
5. OIR-B2-528, "Florida Additional Information Checklist for Debtor Group", Rev. 8/03.
6. OIR-B2-1607, "Discount Medical Plan Organization (DMPO) Contract and Application Checklist", 9/04.
7. OIR-B2-539, "Excess-Specific and Aggregate Checklist", Rev. 1/04.
8. OIR-B2-540, "Informational Memorandum Checklist – Florida Excess Specific and Aggregate – F.S. 624.406", Rev. 1/04.
9. OIR-B2-1356, "Florida HMO Contract Checklist", Rev. 1/04.
10. OIR-B2-1617, "Florida HMO Individual Application Checklist", 1/05.
11. OIR-B2-1618, "Florida HMO Master Group Application Checklist", 1/05.
12. OIR-B2-536, "Franchise Health Application Checklist", Rev. 1/04.
13. OIR-B2-538, "Franchise Health Contract Checklist", Rev. 1/04.
14. OIR-B2-537, "Franchise Health Outline of Coverage Checklist", Rev. 1/04.
15. OIR-B2-525, "Group Health Application Checklist – Employers, Labor Unions, Association Groups and Additional Groups", Rev. 1/04.
16. OIR-B2-526, "Group Health Contract Checklist – Employers, Labor Unions, Association Groups and Additional Groups", Rev. 1/04.
17. OIR-B2-520, "Individual Health Application Checklist", Rev. 1/04.
18. OIR-B2-523, "Individual Health Contract Checklist", Rev. 1/04.
19. OIR-B2-521, "Individual Health Outline of Coverage Checklist", Rev. 1/04.
20. OIR-B2-1619, "Long Term Care Advertisement Checklist", 1/05.
21. OIR-B2-541, "Long Term Care Application Checklist", Rev. 1/04.
22. OIR-B2-543, "Long Term Care Contract Checklist", Rev. 1/04.
23. OIR-B2-542, "Long Term Care Outline of Coverage Checklist", Rev. 1/04.
24. OIR-B2-1620, "Medicare Supplement Advertisement Checklist", 1/05.
25. OIR-B2-1354, "Medicare Supplement Application Checklist", Rev. 1/04.
26. OIR-B2-1355, "Medicare Supplement Contract Checklist", Rev. 1/04.
27. OIR-B2-1621, "Medicare Supplement Outline of Coverage", 1/05.
28. OIR-B2-524, "Out-of-State Group Health Checklist", Rev. 1/04.
29. OIR-B2-1353, "Pre-Paid Limited Benefit Contract Checklist", Rev. 1/04.
30. OIR-B2-1359, "Pre-Paid Limited Benefit Conversion Application Checklist", Rev. 1/04.
31. OIR-B2-1358, "Pre-Paid Limited Benefit Group Application Checklist", Rev. 1/04.
32. OIR-B2-1360, "Pre-Paid Limited Benefit Individual Application Checklist", Rev. 1/04.
33. OIR-B2-1622, "Small Group Advertisement Checklist", 1/05.
34. OIR-B2-1357, "Florida Small Group Health Checklist for Indemnity Plans Other Than Standard and Basic", Rev. 1/04.

(d) Life Checklists.

1. OIR-B2-1624, "Credit Disability Policy Checklist", 1/05.
2. OIR-B2-1625, "Credit Life or Disability Application Checklist", 1/05.
3. OIR-B2-1626, "Credit Life Policy Checklist", 1/05.

4. OIR-B2-1367, "Endorsements, Amendments & Riders Checklist", Rev. 1/04.
5. OIR-B2-1627, "Group Annuity Enrollment Application Checklist", 1/05.
6. OIR-B2-1628, "Group Life Enrollment Application Checklist", 1/05.
7. OIR-B2-1363, "Group Non-Variable Annuity Contract Checklist", Rev. 1/04.
8. OIR-B2-1349, "Group Non-Variable Annuity Enrollment Application Checklist", Rev. 1/04.
9. OIR-B2-1488, "Group Term Life Policy Checklist", Rev. 1/04.
10. OIR-B2-1345, "Group Universal Life Policy Checklist", Rev. 1/04.
11. OIR-B2-1365, "Group Variable Annuity Contract Checklist", Rev. 1/04.
12. OIR-B2-1342, "Group Variable Annuity Enrollment Application Checklist", Rev. 1/04.
13. OIR-B2-1629, "Group Variable Life Enrollment Application Checklist", 1/05.
14. OIR-B2-1489, "Group Variable Life Policy Checklist", Rev. 1/04.
15. OIR-B2-1490, "Group Whole Life Policy Checklist", Rev. 1/04.
16. OIR-B2-1630, "Individual Fraternal Life Application Checklist", 1/05.
17. OIR-B2-1631, "Individual Fraternal Non-Variable Annuity Application Checklist", 1/05.
18. OIR-B2-1632, "Individual Fraternal Non-Variable Annuity Contract Checklist", 1/05.
19. OIR-B2-1382, "Individual Fraternal Term Life Policy Checklist", Rev. 1/04.
20. OIR-B2-1491, "Individual Fraternal Universal Life Policy Checklist", Rev. 1/05.
21. OIR-B2-1633, "Individual Fraternal Variable Annuity Application Checklist", 1/05.
22. OIR-B2-1634, "Individual Fraternal Variable Annuity Contract Checklist", 1/05.
23. OIR-B2-1635, "Individual Fraternal Variable Life Application Checklist", 1/05.
24. OIR-B2-1636, "Individual Fraternal Variable Life Policy Checklist", 1/05.
25. OIR-B2-1314, "Individual Fraternal Whole Life Policy Checklist", Rev. 1/04.
26. OIR-B2-1346, "Individual Life Application Checklist", Rev. 1/04.
27. OIR-B2-1637, "Individual Non-Variable Annuity Application Checklist", 1/05.
28. OIR-B2-1352, "Individual Non-Variable Annuity Contract Checklist", Rev. 1/04.
29. OIR-B2-1493, "Individual Term Life Policy Checklist", Rev. 1/04.
30. OIR-B2-1494, "Individual Universal Life Policy Checklist", Rev. 1/04.
31. OIR-B2-1348, "Individual Variable Annuity Application Checklist", Rev. 1/04.
32. OIR-B2-1364, "Individual Variable Annuity Contract Checklist", Rev. 1/04.
33. OIR-B2-1638, "Individual Variable Life Application Checklist", 1/05.
34. OIR-B2-1384, "Individual Variable Life Policy Checklist", Rev. 1/04.
35. OIR-B2-1496, "Individual Whole Life Policy Checklist", Rev. 1/04.
36. OIR-B2-1350, "Master Group Application Checklist", Rev. 1/04.
37. OIR-B2-1639, "Out-of-State Group Life Enrollment Application Checklist", 1/05.
38. OIR-B2-1640, "Out-of-State Group Non-Variable Annuity Contract Checklist", 1/05.
39. OIR-B2-1641, "Out-of-State Group Non-Variable Annuity Enrollment Application Checklist", 1/05.
40. OIR-B2-1328, "Out-of-State Group Term Life Policy Checklist", Rev. 1/05.
41. OIR-B2-1330, "Out-of-State Group Universal Life Policy Checklist", Rev. 1/05.
42. OIR-B2-1642, "Out-of-State Group Variable Annuity Contract Checklist", 1/05.
43. OIR-B2-1644, "Out-of-State Group Variable Annuity Enrollment Application Checklist", 1/05.
44. OIR-B2-1643, "Out-of-State Group Variable Life Enrollment Application Checklist", 1/05.
45. OIR-B2-1343, "Out-of-State Group Variable Life Policy Checklist", Rev. 1/05.
46. OIR-B2-1329, "Out-of-State Group Whole Life Policy Checklist", Rev. 1/05.
47. OIR-B2-1646, "Viatical Contract Checklist", 3/05.
48. OIR-B2-1647, "Viatical Settlement Escrow Form Checklist", 3/05.
49. OIR-B2-1648, "Viatical Settlement Purchase Agreement Checklist", 3/05.
50. OIR-B2-1649, "Viatical Settlement Related Form Checklist", 3/05.

Specific Authority 624.308 FS. Law Implemented 624.424(1)(c), 627.410, 636.216 FS. History–New 10-29-91, Amended 5-15-96, 4-4-02, 5-2-02, 6-19-03, Formerly 4-149.022, Amended 4-7-05, 1-12-06.

DEPARTMENT OF FINANCIAL SERVICES
Office of Insurance Regulation – Bureau of Life & Health Forms and Rates

UNIVERSAL STANDARDIZED DATA LETTER

What is the purpose of this filing?

(Check one)

- ☐ Forms Only
- ☐ Forms & Rates
- ☐ Rates Only
- ☐ Annual Rate Certification (no rate or benefit changes)

Company Information:

FEIN _____ NAIC Company Code _____

Company Name _____

SECTION I. ~~SUMMARY OF FILING REQUIREMENTS~~INSTRUCTIONS AND INFORMATION

This online form must accompany all Life & Health Form or Rate filings submitted to the Office. If you have questions regarding the information requested, please consult our website at www.floir.com or contact us at (850) 413-3152 (Forms) or (850) 413-3151 (Rates).

	~~FORMS ONLY~~	~~FORMS & RATES~~	~~RATES ONLY~~	~~ANNUAL RATE CERTIFICATION~~
~~1. Standardized Data Letter~~	~~Required~~	~~Required~~	~~Required~~	~~Required~~
~~2. Policy Form~~	~~Required~~	~~Required~~	~~N/A~~	~~N/A~~
~~3. Policy Forms Checklist~~	~~Required~~	~~Required~~	~~N/A~~	~~N/A~~
~~4. Actuarial Demonstration~~	~~Certification that rates are not affected~~	~~Required See Rules 69O-149, 69O-191, 69O-203~~	~~Required See Rules 69O-149, 69O-191, 69O-203~~	~~See Rule 69O-149~~

SECTION II. ~~COMPANY~~ CONTACT INFORMATION

Preferred Email Address: (for all correspondence)

- ☐ I-Portal Account Email
- ☐ Filing Originator Email
- ☐ Company Contact Email
- ☐ Other

Additional Email Addresses:

69O-149.022
OIR-B2-1507
Rev. ~~9/04~~ 06/12

UNIVERSAL STANDARDIZED DATA LETTER

Filing Originator Information

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Contact Name: | Contact Title:

Professional Designation: | Contact Email:

Street Address: | Suite/Room #:

P.O. Box Mailing Address:

Department:

City: | State: | Zip Code: -

Country: | Non US Postal Code:

Phone Number: Ext | Fax Number:

Toll Free Number: Ext | Non US Phone Number:

Company Contact Information

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Contact Name: | Contact Title:

Professional Designation: | Contact Email:

Street Address: | Suite/Room #:

P.O. Box Mailing Address:

Department:

City: | State: | Zip Code: -

Country: _____ Non US Postal Code: _____

Phone Number: _____ Ext _____ Fax Number: _____

Toll Free Number: _____ Ext _____ Non US Phone Number: _____

~~Contact Person~~ _____ ~~FAX #~~ _____

☐ ~~Dr.~~ ☐ ~~Mr.~~ ☐ ~~Mrs.~~ ☐ ~~Ms.~~ ☐ ~~Miss~~ ~~800 #~~ _____

~~Name~~ _____ ~~Professional Designation~~ _____

~~Address~~ _____ ~~Suite~~ _____

_____ ~~E-Mail Address~~ _____

~~Phone~~ _____ ~~Extension~~ _____ ~~Company Filing Number~~ _____

SECTION III. GENERAL INFORMATION

A. Do you currently have in force business on this plan of insurance in Florida? ☐Yes ☐No

~~B. Are you currently selling new business on this plan in Florida? ☐Yes ☐No~~
~~If no, date discontinued _____~~

~~C.~~B. Are you currently selling this plan in other states? ☐Yes ☐No

~~D.~~C. What market restrictions (such as available to military persons only), do you have on this form? _____

D. Is this filing a resubmission of a previously disapproved, withdrawn or incomplete filing? ☐Yes ☐No
If yes, provide Florida file log number: _____

E. Type of company: ☐Profit ☐Non-profit

SECTION IV. LIFE & HEALTH INSURANCE ~~SELECT LINE OF BUSINESS Please review the attached instruction sheet prior to answering the following questions.~~

Life & Annuity Filings - Complete Sections A, B, C and G only

UNIVERSAL STANDARDIZED DATA LETTER

A. Your ~~filing type and associated Certificate of Authority Line of Business~~ policy or coverage is (~~C~~check one)

- ☐ Health
- ☐ Life
- ☐ Variable Life
- ☐ Annuity
- ☐ Variable Annuity

- ☐ ~~Accident & Health (450 General; 430 Fraternal; 455 MEWA)~~
- ☐ ~~Health Maintenance Organizations (718 HMO)~~
- ☐ ~~Prepaid Limited Health Services Organizations (451; 700; 712; 716; 744; 777; 781; 782; 783; 784 PLHSO)~~
- ☐ ~~Health Flex Pans (710)~~
- ☐ ~~Discount Medical Plan Organizations (709 DMPO)~~
- ☐ ~~Continuing Care Retirement Community (720 CCRC)~~
- ☐ ~~Annuity Products (400, 405, 410, 425)~~
- ☐ ~~Life Products (400, 410, 420, 425)~~
- ☐ ~~Credit Life and/or Disability Products (440, 441)~~
- ☐ ~~Viatical Settlements (708)~~
- ☐ ~~Health Advertisements (450 General; 430 Fraternal; 455 MEWA)~~
  - ~~Long Term Care~~
  - ~~Medicare Supplement~~
  - ~~Small Group Major Medical~~

~~Periodic Data Filings (450 General; 430 Fraternal; 455 MEWA)~~

- ☐ ~~A&H Gross Annual Premiums & Enrollment (GAP)~~
- ☐ ~~A&H Employee Health Care Access Act Enrollment (SMG)~~
- ☐ ~~Medicare Supplement Refund Calculation (MSR)~~
- ☐ ~~HMO Gross Annual Premiums & Enrollment (GAP)~~
- ☐ ~~HMO Employee Health Care Access Act Enrollment (SMG)~~

- ☐ ~~Governmental Self Insurance Plan~~

B. Your policy or coverage is (Check one) ☐ Fraternal ☐ Individual ☐ Group

C. Group Policy Characteristics

1) ☐ In-state ☐ Out-of-state

2) ☐ Large Group ~~(51+ lives)~~ Only ☐ Small Group Only (Major Medical - see section 627.6699, F.S.) ~~(1-50 lives)~~ ☐ Small Group Only (Other than Major Medical) ☐ Small and Large Groups (Other than Major Medical)

☐ Other Group (specify) _____

69O-149.022
OIR-B2-1507
Rev. ~~9/04~~ 06/12

3) ☐ Employee Group ☐ Labor Union Group ☐ Debtor Group
☐ Association Group ☐ Additional Group ☐ Other (specify) _____

4) ☐ Blanket Health Policy ☐ Franchise Health Policy

☐ A group to cover persons associated in any other common group, which common group is formed primarily for purposes other than providing insurance.

☐ A group which is established primarily for the purpose of providing group insurance.

☐ A group of insurance agents of an insurer, which insurer is the policyholder.

☐ Other (specify) _____

D. Individual Policy Characteristics

☐ Optionally Renewable ☐ Guaranteed Renewable ☐ Non-Renewable
☐ Conditionally Renewable ☐ Non-Cancelable ☐ Other (specify) _____

E. Is your Policy or Coverage primarily for individuals over 65? ☐ ~~y~~Yes ☐ ~~n~~No

F. ~~If applicable, select Accident and Health Product Type:~~Check the types of benefit(s) your policy or coverage provides:

☐ Disability Income
☐ Long Term Care
☐ Medicare Supplement
☐ Health Maintenance Organization
☐ ~~Accident Only~~
☐ ~~AD&D~~
☐ ~~Blanket or Student Accident or Sickness~~
☐ ~~Champus or Tricare Supplement~~
☐ ~~Dental~~
☐ ~~Group Conversion~~
☐ ~~Disability Income~~
☐ ~~Dread or Specified Disease~~
☐ ~~Excess or Stop Loss~~
☐ ~~Long Term Care~~
☐ Major Medical
☐ Prepaid Limited Health Service Organization
☐ Small Employer Group Coverage (see Section 627.6699, F.S.)
☐ Other (specify) _____
☐ ~~Hospital Indemnity~~
☐ ~~Hospital/Surgical/Medical Expense~~
☐ ~~Major Medical~~
☐ ~~Medicare Supplement~~
☐ ~~Prescription Drug~~
☐ ~~Short Term Care~~
☐ ~~Sickness Only~~
☐ ~~Vision~~
☐ ~~Other (specify) _____~~

~~G. If applicable, select Life and Annuity Product Type:~~

~~☐ Life – Assumption Agreement~~
~~☐ Life – Term~~
~~☐ Life – Variable~~
~~☐ Life – Other (specify) _____~~
~~Annuities – Immediate Non-Variable Benefit~~
~~Single Premium ☐~~
~~Other ☐ (specify) _____~~
~~Annuities – Deferred Non-Variable Benefit~~
~~Fixed Premium ☐~~
~~Flexible Premium ☐~~
~~Single Premium ☐~~
~~Other ☐ (specify) _____~~
~~☐ Annuities – Other (specify) _____~~

~~☐ Life – Endowment~~
~~☐ Life – Universal~~
~~☐ Life – Whole~~

~~Annuities – Immediate Variable Benefit~~
~~Single Premium ☐~~
~~Other ☐ (specify) _____~~
~~Annuities – Deferred Variable Benefit~~
~~Fixed Premium ☐~~
~~Flexible Premium ☐~~
~~Single Premium ☐~~
~~Other ☐ (specify) _____~~

SECTION V. ~~INSURANCE PRODUCT FILING~~ RATE FILING HISTORY – INCLUDING ANNUAL RATE CERTIFICATIONS

(This section is for Florida experience only; not applicable for new form filings)

	(1)	(2)	(3)	(4)	(5)	~~(5)~~(6)	(7)	~~(6)~~(8)	~~(7)~~(9)	(10)
		Total Annualized Premium Volume	# of Group Certificates ~~/ Subscribers~~ or Individual Policies	Average Rate Change Requested (0.0% for ARC Filings)	Minimum Rate Change Requested (0.0% for ARC Filings)	Maximum Rate Change Requested (0.0% for ARC Filings)	Average Benefit Change Requested (0.0% for ARC Filings)			Effective Date of Change (N/A for ARC Filings)
Current Filing		$								
	Average Rate Change Requested	Total Annualized Premium Volume	# of Group Certificates ~~/ Subscribers~~ or Individual Policies	Average Rate Change Approved	Minimum Rate Change Approved	Maximum Rate Change Approved	Average Benefit Change Approved	Date Change Approved or Acknowledged	Florida Filing Number	Effective Date of Change
1st Prior Filing	%	$		%		%				

2nd Prior Filing	%	$		%		%						

NOTE: Dates for columns (8) and (10) must be in the format mm/dd/yyyy.

SECTION VI. RATE REQUEST BY FORM – INCLUDING NEW FORM SUBMISSIONS

(To be completed for all rate filings ~~which include pooled blocks~~, including ARC filings - Florida experience only. ~~Attach an additional page as necessary.~~)

(1) Form Number	(2) Base Form or Rider	(3) Marketing Product Name (Street Name)	~~(2)~~ (4) Average Rate Change Requested (0.0% for ARC Filings)	(5) Minimum Rate Change Requested (0.0% for ARC Filings)	(6) Maximum Rate Change Requested (0.0% for ARC Filings)	(7) Average Benefit Change Requested (0.0% for ARC Filings)	~~(3)~~ (8) Total Annualized Premium Volume	(9) Total Incurred Claims	~~(4)~~ (10) # of Group Certificates or Individual Policies	(11) # of Covered Dependents/ Additional Lives	(12) # of Covered Lives (10+11)	(13) Inception Date or New Form	(14) Discontinued Date (If Applicable)	(15) Number of Member Months (Major Medical Only)	(16) Major Medical Coverage Type (Select All That Apply)
															HMO, PPO, Indemnity, POS, FFS, EPO, HSA, HDHP

MAJOR MEDICAL FORMS ONLY

Please enter one claim per row for each unique incurred claim over $500,000 for last five (5) years by year:

(1) Amount	(2) Incurral Year

SECTION VII. ADDITIONAL DATA FOR ~~NEW FORM & RATE INSURANCE PRODUCT~~ ALL RATE FILINGS

(Please provide current data for the form(s) ~~submitted~~ included in the filing and listed in section VI.)

	Florida Only	Nationwide

UNIVERSAL STANDARDIZED DATA LETTER

			☐ Same as Florida	
A. Number of Group Certificates or Individual Policies ~~Affected~~:				
B. If Group, Average Number of Certificates Per Policy/ Participating Unit (e.g. Employer Unit)				
C. Total Annualized Premium Volume (Prior / Projected)	$	$	$	$
D. Total Incurred Claims (Prior / Projected)	$	$	$	$
~~D.~~E. Average Annual Premium (Current / Pproposed or new form)	$	$	$	$
~~E.~~F. Anticipated Loss Ratio (Current / Proposed Premium)	%	%	%	%
~~F.~~G. Lifetime Loss Ratio (Current / Proposed Premium)	%	%	%	%
~~G.H. Loss Ratio Standard for The Form (or pooled group/forms)~~ Target Loss Ratio for Individual or Group Forms (Not the Minimum: Expected Loss Ratio for Annually Rated Groups: Weighted average by form and/or group size where applicable)		%		%
~~H.~~I. Total Past Incurred Loss Ratio Without Active Life Reserve Increases		%		%
~~I.~~J. Latest Calendar~~Current~~ Year Loss Ratio for Policies 3 Years & Older (For Med. Supp.) Without Policy Reserves:		%		%
K. Anticipated Actual-to-Expected Loss Ratio (Current / Proposed)	%	%	%	%
L. Lifetime Actual-to-Expected Loss Ratio (Current / Proposed)	%	%	%	%
M. Total Past Actual-to-Expected Loss Ratio		%		%
N. Valuation Date of Data (applies to all data in this section)				

SECTION VIII. Rate Filing Certification

I certify that I am authorized to make this Rate Filing on behalf of the company, further that the information contained in related transmittals and the filing is true, complete, correct, and in compliance with all applicable state laws. ~~Please upload and/or attach required certification documents.~~

(Check one)

☐ I am an actuary
☐ I am not an actuary

Name:	Title:

SECTION IX. Readability Certification

If you are not required to certify READABILITY compliance per Section 627.4145, F.S., please complete Section IX by checking the box, typing your name and substituting "READABILITY NOT APPLICABLE" in the title field.

UNIVERSAL STANDARDIZED DATA LETTER

I certify that the filing of this policy meets the requirements of Section 627.4145 (1), Florida Statutes, in the following manner (check one)

☐ the policy meets the minimum reading ease test score on the test used or;

☐ the score is lower than the minimum required but should be approved in accordance with Subsection 627.4145 (2), Florida Statues.

I acknowledge that the Oeffice may require the submission of further information to verify this certification.

Name:	Title:

SECTION X. Checklist Certification

I have reviewed or supervised the review of the policy form(s) that this filing describes. I hereby certify that the statements made in this filing are in compliance with applicable Florida Statutes and Rules. I further certify it will be revised and/or discontinued if the Office determines that the form(s) does not comply with Florida law.

Name:	Title:

SECTION XI. ~~FORMS INFORMATION~~ Forms To Be Reviewed

Please provide the following information for the form(s) submitted with this filing.

Form Title	~~Type of Form~~	~~New~~ Form Number	~~Florida File #~~ Original Filing Number	~~Replaced Form #~~ Original Form Number

OFFICE OF INSURANCE REGULATION

Life & Health Product Review

UNIVERSAL STANDARDIZED DATA LETTER INSTRUCTIONS

Only one Universal Standardized Data Letter (UDL) may be provided in each filing. Revised UDLs may be submitted to correct information and will replace any previous submissions within the same filing.

~~ALL SUBMISSIONS~~

Section I. Instructions and Information: ~~Review this section for applicable filing requirements.~~

Section II. Contact Information: Provide the requested contact information for both the filing originator and the company contact~~about the company and identify a person to be contacted regarding the filing~~. Select the preferred email address to be used for all correspondence. Provide additional email addresses to be copied on all correspondence, separated by a semi-colon. This section must be filled out for all filings.

Section III. General Information: This ~~form needs to~~ section must be filled out for all filings.

Section IV. Life & Health Insurance: Select the applicable filing and product characteristics. ~~Provide type of filing information (i.e. life or annuity, group, in-state, etc.) -- See more detail under rates portion.~~

~~The complete filing should be sent to: **Bureau of L&H Forms & Rates**~~
~~**Office of Insurance Regulation**~~
~~**Submitted through https://iportal.fldfs.com**~~

~~FORMS PORTION~~

~~Section IX: An officer of the company must certify as to the readability of the forms.~~

~~Section X: An officer of the company or a designated compliance person must certify that all the information provided is correct.~~

~~Section XI: Title is the name of the product, for example "Trendsetter 20." Type of form is the type of insurance policy, such as "Term Life Insurance Policy." New Form number is the form number you have at the time of filing. Replaced Form number is the number of the form, which will be discontinued for future sales that you are replacing, if applicable. This does not mean individual insureds are having their coverage cancelled and replaced. Office of Insurance Regulation File Number is for form replaced.~~

ADDITIONAL FORMS INFORMATION:

1. ~~A letter of transmittal explaining the type and nature of the filing (see Rules 69O-149.021(1)(b)1., and 69O-149.023(4), F.A.C.)~~
2. ~~Do not include filings for more than one company with each submission.~~
3. ~~Complete the appropriate checklist for each filing.~~
4. ~~A certification that the representative making the filing, if someone other than a company employee, has been authorized to do so by an officer of the company.~~
5. ~~Advertisements should be submitted as a separate filing and not as part of a form filing.~~
6. ~~When responding to Office correspondence regarding a filing, please correspond directly with the analyst, referencing our filing number.~~

~~RATES PORTION~~

~~Section III: General Information:~~
~~This form needs to be filled out for all filings, including Annual Rate Filing Certifications.~~

Section IV.C. Group Policy Characteristics:

~~Group Policy Characteristics~~	Life groups defined in:	Health groups defined in:
Employee Groups	Section 627.552, F.S.	Section 627.653, F.S.

Labor Union Groups	Section 627.554, F.S.	Section 627.654, F.S.
Debtor Groups	Section 627.553, F.S.	Section 627.655, F.S.
Association Groups	Section 627.5567, F.S.	Section 627.654, F.S.
Additional Groups	Section 627.5565, F.S.	Section 627.656, F.S.
Blanket Health Insurance	not applicable	Section 627.659, F.S.
Franchise Health Insurance	not applicable	Section 627.663, F.S.

Section IV.D. Individual Policy Characteristics:

Optionally Renewable:
Renewal can be declined at the option of the insurance company.

Conditionally Renewable:
Renewal can be declined by class, by geographic area or for stated reasons other than the deterioration of health.

Guaranteed Renewable:
The insurance company cannot be declined renewal for any reason. Yet, the insurance company can revise rates on a class basis. (See also Sections 627.6425 & 627.6571, F.S.)

Non-Cancelable:
Renewal cannot be declined and the insurance company cannot revise the rates.

Non-Renewable:
There is a contractual provision that prevents a policy duration of more than one year.

Section V.: ~~RATE FILING HISTORY~~Rate Filing History – Including Annual Rate Certifications - ~~To be completed for all policies whose rates are subject to regulatory authority.~~

This section is for Florida experience only ~~on the total of forms combined for this filing~~ and reflects aggregate data. Please provide the information for the current filing and the two most recent rate ~~revision~~ filings that were either approved or acknowledged, if applicable.

(1) Average Rate Cchange Rrequested - Tthe percentage increase in the average annualized premium being requested. The average annualized premium should be calculated on the basis of the inforce distribution. Value reflects entire base rate change; exclude only trend. Trend implemented annually is treated as a base rate change and is included. Not applicable to the current filing; requested rate change for current filing is in column (4).

(2) Total Annualized Premium Volume - Total premium volume, on an annualized premium basis, for the inforce policies at the valuation date for~~time of~~ the related filing.

(3) Number of Group Certificates/~~Subscribers~~ or Individual Policies - For group coverage, provide the number of certificates/subscribers in force at the valuation date for the related filing. For individual coverage, ~~and~~provide the number of policies ~~for individual~~ at the valuation date for the related filing. The total count should be provided, and should include policies with no premium. Policies in a delinquent status should be included.

(4) Average Rate Change - The ~~amount of~~ average rate revision requested, or for prior filings, the ~~amount of~~ average rate revision approved, expressed as the percentage increase in the average annual premium. Value reflects entire base rate change; exclude only trend. Trend implemented annually is treated as a base rate change and is included.

(5) Minimum Rate Change – The smallest increase due to the filing affecting any specific individual policyholder or group certificateholder. For the current filing, this is the requested value. For any prior filings, this is the approved value. Value reflects entire base rate change; exclude only trend. Trend implemented annually is treated as a base rate change and is included.

(~~5~~6) Maximum Rate Change Approved - The largest increase due to the filing affecting any specific individual policyholder/~~subscriber~~ or group certificateholder. For the current filing, this is the requested value. For any prior filings, this is the approved value. Value reflects entire base rate change; exclude only trend. Trend implemented annually is treated as a base rate change and is included.

(7) Average Benefit Change – The average benefit revision requested, or for prior filings, the average benefit revision approved, expressed as a percentage increase in the benefit schedule. Benefit changes due to changes in duration or aging should not be included.

(68) Date Change Approved or Acknowledged - The ~~Office's~~ date the prior filing was closed. ~~of approval of the rate revision filing~~. Not applicable to the current filing. Dates must be in mm/dd/yyyy format.

(~~7~~9) Florida Filing Number – Tthe Florida ~~filing~~ file log number~~, i.e. FLR 98-1234~~, (ex: 11-12345) which identifies the filing. File log numbers must be in ##-##### format without text. Not applicable to the current filing.

(10) Effective Date of Change – For the current filing, provide the target effective date of the requested rate and/or benefit change. For prior filings, provide the effective date of the approved rate and/or benefit change. Not applicable for filings with no rate or benefit changes. Dates must be in mm/dd/yyyy format.

Section VI. ~~RATE REQUEST BY FORM~~Rate Request By Form – Including New Form Submissions - To be completed for all rate filings. This is all filings that involve a rates section review (ex. Rate Only filings, Forms and Rates filings, ARC filings). ~~policies whose rates are subject to regulatory authority. New forms should submit the form number in (1).~~

This section is for Florida experience only. Each form included in the filing must be listed individually. Additional form rows may be added. Forms such as applications and outlines of coverage do not need to be listed. Riders should be included. If the premium for a base policy and a rider cannot be separated, the rider should still be included in this section and the number of individual policyholders or group certificateholders should be provided.

(1) Form Number - The form number of the form being filed. Only one form number should be listed in each row. Riders should be included. The form number should exactly match the form number on the form; all special characters, spaces, and letters must be included.

(2) Base Form or Rider – Indicate if the form listed is a base form or a rider.

(3) Marketing Product Name (Street Name) – The name used to market or advertise the form. This is not the form number. Leave blank if not applicable.

(~~2~~4) Average Rate Cchange Rrequested - Tthe requested percentage increase in the average annual premium for only the applicable form. The average annual premium should be calculated on the basis of the inforce distribution. 0.0% for new forms and annual rate certification filings. Value reflects entire base rate change; exclude only trend. Trend implemented annually is treated as a base rate change and is included.

(5) Minimum Rate Change Requested - The smallest requested increase affecting any specific individual policyholder or group certificateholder on only the applicable form. 0.0% for new forms and annual rate certification filings. Value reflects entire base rate change; exclude only trend. Trend implemented annually is treated as a base rate change and is included.

(6) Maximum Rate Change Requested - The largest requested increase affecting any specific individual policyholder or group certificateholder on only the applicable form. 0.0% for new forms and annual rate certification filings. Value reflects entire base rate change; exclude only trend. Trend implemented annually is treated as a base rate change and is included.

(7) Average Benefit Change Requested - The average benefit revision requested on only the applicable form expressed as a percentage increase in the benefit schedule. Benefit changes due to changes in duration or aging should not be included. 0.0% for new forms and annual rate certification filings.

(~~3~~8) Total Annualized Premium Volume - Total premium volume, on an annualized premium basis, for the inforce policies at the valuation date for~~time of~~ the ~~related~~ filing for only the applicable form.

(9) Total Incurred Claims – Total amount of claims occurring in the twelve months prior to the valuation date for the filing, whether or not paid during that time, for only the applicable form.

(410) Number of Group Certificates or Individual Policies - For group coverage, provide the number of certificates in force, for only the applicable form, at the valuation date for the filing. For individual coverage, ~~and~~provide the number of policies ~~for individual~~, for only the applicable form, at the valuation date for the related filing. The total count should be provided, and should include policies with no premium. Policies in a delinquent status should be included. For filings including base and rider forms, the sum of these fields may not equal the total fields in section V and VII because insureds with selected riders will be counted multiple times.

(11) Number of Covered Dependents/Additional Lives – The total number of dependents, excluding primary insureds, and/or the total number of additional lives (ex: for joint coverage with two primary insureds, there is one additional life).

(12) Number of Covered Lives – Automatically calculated as column (10) plus column (11).

(13) Inception Date or New Form – Provide the date the form was approved or indicate that the form is new. A form is new if it has never been approved by the Office. Dates must be in mm/dd/yyyy format.

(14) Discontinued Date – Provide the date the form was closed to new sales. Leave blank if the form is currently available for sale. Dates must be in mm/dd/yyyy format.

(15) Number of Member Months – Applies to Major Medical coverage only.

(16) Major Medical Coverage Type – Select all applicable coverage types. Applies to Major Medical coverage only.

For Major Medical Forms Only, complete the large claims table. There should be only one claim per row. A claim is counted as the first incidence or diagnosis of an event resulting in a covered benefit or series of covered benefits. If an insured has had more than one large claim in a calendar year, the claims should be listed on multiple rows. Additional rows may be added.

(1) Amount – Provide the dollar amount of the incurred claim. Please enter only one claim per row.

(2) Incurral Year – Provide the calendar year in which the claim was incurred in YYYY format.

Section VII.: ~~ADDITIONAL DATA~~ Additional Data For All Rate Filings - To be completed for all ~~policies whose rates are subject to regulatory authority. (Do Not Reference Attachments)~~ rate filings. This is all filings that involve a rates section review (ex. Rate Only filings, Forms and Rates filings, ARC filings).

This section is reflects aggregate data for both Florida and Nationwide. Provide current data for the form(s) included in the filing which are listed in section VI. If there is no experience outside of Florida, the nationwide section should be identical to the Florida section.

A. Number of Group Certificates~~/Subscribers~~ or Individual Policies ~~Affected~~ - For group coverage, provide the number of individual certificates or subscribers in force. For individual coverage, ~~and~~provide the number of policies ~~for individual~~. The total count should be provided, and should include policies with no premium. Policies in a delinquent status should be included.

B. Average Number of Certificates ~~or Subscribers~~ Per Policy – ~~If~~Applies only to group coverage. (A + B should yield the number of groups)

C. Total Annualized Premium Volume - Premium volume, on an annualized premium basis, for the current inforce policies at the valuation date for the filing. The prior amount reflects the annualized premium before any rate changes. The projected amount reflects the projected annualized premium twelve months following the effective date for the filing, taking into consideration lapses (if applicable) and any proposed rate changes, but assumes no new issues. The prior value should equal the sum of column (8) in section VI.

D. Total Incurred Claims - Total dollar amount of claims occurring in a year, whether or not paid during that year. The prior amount reflects the twelve months prior to the valuation date for the filing. The projected amount reflects the twelve months following the effective date for the filing, taking into consideration lapses (if applicable) and any proposed benefit changes, but assumes no new issues. The prior value should equal the sum of column (9) in

section VI.

~~D.~~E. Average Annual Premium - The average annualized premium based on the inforce ~~age/sex/area, etc.~~ distribution of ~~inforce~~ policies. The current value should reflect the current average annual premium with no changes. The proposed value should reflect the current value including proposed changes to base premiums; trend not included. For new forms, a value should be provided in the proposed field. ~~The average annualized premium anticipated for a new policy form should be included here.~~

~~E.~~F. Anticipated Loss Ratio – The present values of future claims, divided by the present value of future earned premiums ~~on the proposed rate basis over the block of business~~. The current value should assume no rate and/or benefit changes. The proposed value should reflect the proposed rate and/or benefit changes. For new forms, a value should be provided in the proposed field. ~~This should also be included for new form filings. Current is before any rate change.~~

~~F.~~G. Lifetime Loss Ratio – The present values of incurred claims, past and ~~expected~~ future, divided by the present value of earned premiums, past and ~~expected~~ future~~, on both the current and proposed rate basis~~. The current value should assume no rate and/or benefit changes. The proposed value should reflect the proposed rate and/or benefit changes. For new forms, a value should be provided in the proposed field. ~~Current is before any rate change.~~

~~G.~~H. Target Loss Ratio – The originally filed lifetime loss ratio standard for the form, established at pricing or revised and approved by the Office, and should be equivalent to the present value of the durational loss ratio curve. Applies to both individual and group coverage. This is not the minimum loss ratio established in Rule. For annually rated group products, this is the expected or anticipated loss ratio. For pooled blocks, this is the weighted average by form and/or group size. For new forms, a value is required. ~~If the standard has been increased in prior rate filings due to certification of a higher standard, this should reflect this higher standard.~~

~~H.~~I. Total Past Incurred Loss Ratio Without Active Life Reserve Increases – The accumulated value of past incurred claims divided by the accumulated value of the past earned premiums.

~~I.~~J. Latest Calendar~~Current~~ Year Loss Ratio for Policies 3 Years and Older (for Medicare Supplement) without Policy Reserves – The loss ratio, for the most recently completed calendar year for those policies or certificates which have been in force for 3 or more years.

K. Anticipated Actual-to-Expected Loss Ratio – The ratio of the actual anticipated loss ratio divided by the future expected loss ratio. This is equivalent to the present value of the projected incurred claims divided by the present value of the future expected incurred claims.

L. Lifetime Actual-to-Expected Loss Ratio – The ratio of the actual lifetime loss ratio divided by the lifetime expected loss ratio. This is equivalent to the present value of the past and projected incurred claims divided by the present value of the past and future expected incurred claims.

M. Total Past Actual-to-Expected Loss Ratio – The ratio of the actual past loss ratio divided by the past expected loss ratio. This is equivalent to the present value of the past incurred claims divided by the present value of the past expected incurred claims.

N. Valuation Date of Data – The point in time at which the data was determined. This date separates the past and future experience.

Section VIII. Rate Filing Certification – A qualified actuary, an officer of the company, or a designated compliance person must certify to the rate information provided.

Section IX. Readability Certification – An officer of the company must certify as to the readability of the forms.

Section X. Checklist Certification – An officer of the company or a designated compliance person must certify that all the information provided is correct.

Section XI. Forms To Be Reviewed

Form Title - The name of the form, for example "Application for Base Form ABC-FL." If submitting a form, this field is

required.

Form number - The form number present on the form being submitted in the filing. If submitting a form, this field is required.

Original Filing Number – The Florida file log number of the filing in which the original form was filed and approved. File log numbers must be in ## ##### format without text.

Original Form Number - The number of the form, which will be discontinued for future sales, that is being replaced, if applicable.

690-149.022
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.

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.

627.410 Filing, approval of forms.—

(1) No 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, or group certificates issued under a master contract delivered in this state, or printed rider or endorsement form or form of renewal certificate, shall be delivered or issued for delivery in this state, unless the form has been filed with the office by or in behalf of the insurer which proposes to use such form and has been approved by the office. This provision does not apply to surety bonds or to policies, riders, endorsements, or forms of unique character which are designed for and used with relation to insurance upon a particular subject (other than as to health insurance), or which relate to the manner of distribution of 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. As to 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 not less than 30 days in advance of any such use or delivery. At the expiration of such 30 days, the form so filed will be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the office. The approval of any such form 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 form, 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 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 shall not deliver or 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 shall be for informational purposes.

(c) Every filing made pursuant to this subsection shall be made within the same time period provided in, and shall be deemed to be approved under the same conditions as those provided in, subsection (2).

(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, shall be prohibited from applying the following rating practices:

1. Select and ultimate premium schedules.
2. Premium class definitions which 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 shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.

1. An insurer may discontinue the availability of a policy form if the insurer provides to the office in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer shall no longer offer for sale the policy form or certificate form in this state.
2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. shall not file for approval a new policy form providing similar benefits as the discontinued form for a period of 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.
3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes.

(7)(a) Each insurer subject to the requirements of subsection (6) shall make an annual filing with the office no later than 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. 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.

(b) The filing required by this subsection 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 promulgated by the commission.

2. If no rate change is proposed, a filing which 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.

(c) As used in this section, "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 with 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.

(d) 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.

(e) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days following 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.

636.216 Charge or form filings.—

(1) All charges to members must be filed with the office and any charge to members greater than $30 per month or $360 per year must be approved by the office before the charges can be used. The discount medical plan organization has the burden of proof that the charges bear a reasonable relation to the benefits received by the member.

(2) There must be a written agreement between the discount medical plan organization and the member specifying the benefits under the discount medical plan and complying with the disclosure requirements of this part.

(3) All forms used, including the written agreement pursuant to subsection (2), must first be filed with and approved by the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form.

(4) A charge or form is considered approved on the 60th day after its date of filing unless it has been previously disapproved by the office. The office shall disapprove any form that does not meet the requirements of this part or that is unreasonable, discriminatory, misleading, or unfair. If such filings are disapproved, the office shall notify the discount medical plan organization and shall specify in the notice the reasons for disapproval.

M E M O R A N D U M

DATE: March 15, 2012

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Bob Prentiss

SUBJECT: Cabinet Agenda for ~~April 24~~, 2012
Request for Approval to Publish Repeal to
Rule 69O-164.030
Application of rule 69O-164.020, F.A.C., to Various Product Designs; Repeal
Assmt. # 122864-12

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before April 18, 2012 and to the Financial Services Commission on April 24, 2012, with a request to approve the proposed rules for publication.

The Office of Insurance Regulation has recently conducted a comprehensive review of all agency rules to determine whether any of its rules should be modified or eliminated. As a result of this process, it has been determined that Rule 69O-164.030, Florida Administrative Code, is unnecessary and should be repealed.

The National Association of Insurance Commissioners ("NAIC") Accounting Practices and Procedures Manual was adopted by the Office in Rule 69O-137.001, Florida Administrative Code. The purpose of Rule 69O-164.030, Florida Administrative Code, is to allow the Office to deviate from step 8A through step 8C of Actuarial Guideline 38 which is contained in Volume II Appendix C of the NAIC Accounting Practices and Procedures Manual.

Actuarial Guideline 38 deals with reserving approaches that need to be established for guarantees that are provided by a policy. Steps 8A through 8C deal with reserves for universal life policy guarantees.

Pursuant to the Accounting Practices and Procedures Manual:

- step 8A applies to universal life policies issued prior to July 1, 2005
- step 8B applies to universal life policies issued on or after July 1, 2005 and prior to December 31, 2006. Step 8B also applies to universal life policies issued after January 1, 2014
- step 8C applies to universal life policies issued on or after January 1, 2007 and prior to December 31, 2013.

Based upon the text of Actuarial Guideline 38 contained in the Accounting Practices and Procedures Manual, all universal life policies issued after January 1, 2014 would have to meet the reserve standards laid out in step 8B. The Office feels that it would be in the best interest of Florida consumers to have 8A to apply to universal life policies when step 8C is no longer available (currently January 1, 2014) instead of step 8B. The purpose of Rule 69O-164.030, Florida Administrative Code, is to achieve the Office's goal of deviating from Actuarial Guideline

38. The net effect of the Rule is to have step 8A apply to universal life policies when step 8C is no longer available instead of having 8B apply.

It now appears that the NAIC will continue to extend the expiration date of step 8C indefinitely. As a result, Rule 69O-164.030, Florida Administrative Code is not necessary.

Sections 624.308(1), 625.121(5),624.307(1), 625.121(5), FS.provide rulemaking authority and laws implemented for this rule.

JR Jason Nelson 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:

Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-164.030 Application of Rule 69O-164.020, F.A.C., to Various Product Designs

Specific Authority 624.308(1), 625.121(5) FS. Law Implemented 624.307(1), 625.121(5) FS. History–New 5-4-06, Amended 1-16-08, Repealed.

69O-164.030 Application of Rule 69O-164.020, F.A.C., to Various Product Designs.

(1) Purpose. The purpose of this rule is to provide direction as to the application of Rule 69O-164.020, F.A.C., to various product designs developed after March, 1999. Specifically, this rule provides examples of various policy features that constitute "guarantees" and gives directions on how to reserve for these guarantees in accordance with Rule 69O-164.020, F.A.C. Obviously, new policy designs will emerge subsequent to the development of this rule. No statute, rule, or guideline can anticipate every future product design, and common sense and professional responsibility are needed to assure compliance with both the letter and the spirit of the law. While Rule 69O-164.020, F.A.C., is a complex regulation, its intent is clear: reserves need to be established for the guarantees provided by a policy. Policy designs that are created to simply disguise those guarantees or exploit a perceived loophole must be reserved in a manner similar to more typical designs with similar guarantees.

(2) Application. The list below specifies reserving approaches which the Office regards as being most consistent with the letter and spirit of Rule 69O-164.020, F.A.C. However, the specified reserving approaches should be modified as needed to comply with the intent of this rule that similar reserves be established for policy designs that contain similar guarantees.

(a)1. Situation: An initial level premium rate is guaranteed for 10 years followed by increased guaranteed premiums for an additional 20 years. However, the company cannot increase premiums after year 10 (i.e., the initial premium continues to be charged) unless some specified event occurs.

2. Application: The initial reserve segment is 30 years. Since the contract contains provisions that limit the company's ability to increase premiums, then the initial premium should be treated as guaranteed for the entire 30 year period. It would be contrary to the conservative nature of statutory accounting to treat this policy the same as one in which the ability to raise premiums is unrestricted.

(b)1. Situation: A term policy has an illustrated level premium for 30 years, the first 10 of which are guaranteed. Additionally, there is a refund option which provides that a specified refund will be paid if the premium ever increases. The refund must be requested within a limited time (e.g., 30 days) of receiving notice of the increase. Coverage terminates if the option is exercised.

2. Application: This example differs from the one above in that there is no specified event that has to occur in order for the company to impose a premium increase; however, the company must provide an additional benefit to the policyholder if it exercises this right. Thus the company does not have an unrestricted right to impose an increase after 10 years. If the contract contains provisions that require that additional benefits be provided to the policyholder in the event of a premium increase, even if these benefits are lost if not claimed within a stated time frame, then the initial premiums should be treated as guaranteed for the entire 30 year period. It would be contrary to the conservative nature of statutory accounting to treat this policy the same as one in which the ability to raise premiums does not require that additional benefits be provided. Therefore, the initial segment for this policy is 30 years.

(c)1. Situation: An initial level premium rate is guaranteed for 10 years followed by increased guaranteed premiums for an additional 20 years. However, after year 10 the policyholder is protected against premiums being increased above the initial level, with the protection provided by a second company through either reinsurance, a second policy issued to the consumer, or an agreement between the companies.

2. Application: The combined reserves of the direct writer and the second company should be no less than the amount which the direct writer would hold if a) there were no second company and b) the initial reserve segment were 30 years. If this condition is not met, reserve credits for the direct writer should be disallowed. The reserve held by the direct writer should be based on the initial level premium being guaranteed for 30 years.

(d)1. Situation: A product has relatively high gross premiums but with a guaranteed dividend or guaranteed refund schedule, or by some other means guarantees a low net cost to the policyholder.

2. Application: The net amount of premium (i.e., gross premium less dividends or refunds) should be used in the reserve calculation. That represents the amount the insured actually pays for coverage. For products reinsured on either a coinsurance or modified coinsurance basis, the reinsurer's reserve calculation should also be based on the net premium (i.e., gross premiums less dividends or refunds guaranteed to be paid to the policyholder).

(e)1. Situation: A re-entry term product has an initial rate guarantee for 10 years, with loose or non-existent re-entry underwriting, allowing the policyholder to re-enter for an additional 20 years at specified favorable rates.

2. Application: The reentry periods and premiums should be treated as a continuation of the initial guarantees for reserve calculation purposes. The initial reserve segment applicable to the original policy should be 30 years if the stipulated premium for the substitute policy is not high enough to trigger a new reserve segment. When the substitute policy is issued, reserves should be determined as if the coverage had been issued at the issue age and issue date of the original policy. Effectively, the company has guaranteed coverage for 30 years at the time the initial policy is issued, and the reserves established should reflect that guarantee.

(f)1. Situation: A universal life policy has provisions such that, if the UL policy lapses prior to the 10th policy anniversary because the actual accumulation value (or cash value, depending on design) falls below zero but stipulated premiums have been paid, a substitute policy is guaranteed to be issued providing the same amount of insurance coverage at the same stipulated premium for the remainder of the 10-year period plus an additional 20 years.

2. Application: The reentry periods and premiums should be treated as a continuation of the initial guarantees for reserve calculation purposes. The initial reserve segment applicable to the original policy should be 30 years if the stipulated premium for the substitute policy is not high enough to trigger a new reserve segment. When the substitute policy is issued, reserves should be determined as if the coverage had been issued at the issue age and issue date of the original policy. Effectively, the company has guaranteed coverage for 30 years at the time the initial policy is issued, and the reserves established should reflect that guarantee.

(g)1. Situation: A reinsurance treaty provides for 30 years of level premiums on a current scale but directly guarantees those premiums for only the first 10 years. However, if the reinsurer increases the premiums after 10 years, the reinsurer agrees to increase the expense allowance such that the net payments (premium minus allowance) by the direct writer remains unchanged.

2. Application: Relative to the reinsurer's reserve calculation, the initial reserve segment should be 30 years and the valuation premium should be level over that period. In this instance, the additional "expense allowance" has no relationship to the expenses actually incurred by the direct writer in administering the reinsured policies. Although a bona fide expense allowance would typically not be considered in determining the valuation premiums and reserve segments, in this instance the additional "expense allowance" has no relationship to the expenses actually incurred by the direct writer in administering the reinsured policies."

(h)1. Situation: A universal life policy has a cumulative "premium catch-up provision" in which the coverage is guaranteed to remain in force as long as a stipulated premium is paid each year, and if the insured is paying less than is required to maintain the guarantee, there is an unlimited right to make up past premium deficiencies.

2. Application: Rule 69O-164.020, F.A.C., requires that "when a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees." Since secondary guarantees with "catch-up" provisions are capable of being reinstated up to the end of the secondary guarantee period, they constitute "unexpired secondary guarantees" which must be incorporated into the calculation of "the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees."

3. The basic and deficiency reserves for a secondary guarantee with a catch-up provision should be computed as if the stipulated premium requirement had been met. The basic reserve shall be reduced by the product of a) the "catch-up amount," if any, which would be required on the valuation date and b) the ratio of the "initial" (i.e., before adjustment) basic reserve to the sum of the "initial" basic and deficiency reserves. In no event shall the "reduced" basic reserve be reduced below zero. The deficiency reserve shall be reduced by the product of a) the "catch-up amount," if any, which would be required on the valuation date and b) the ratio of the "initial" deficiency reserve to the sum of the "initial" basic and deficiency reserves. In no event shall the "reduced" deficiency reserve be reduced below zero.

4. If a universal life policy with a "premium catch up provision" has a shadow account below the level necessary to maintain the secondary guarantee, then the reserve for the secondary guarantee shall be valued

according to this example. The basic and deficiency reserves, before deduction for the catch-up amount, shall be calculated as specified in paragraph (i).

(i) A universal life policy guarantees the coverage to remain in force as long as the accumulation of premiums paid satisfies the secondary guarantee requirement.

1. For policies and certificates issued prior to July 1, 2005, and for policies and certificates issued on or after January 1, 2011:

a. First, the minimum gross premiums (determined at issue) that will satisfy the secondary guarantee requirement must be derived.

b. Second, for purposes of applying paragraphs (7)(b) and (c) of Rule 69O-164.020, F.A.C., the "specified premiums" are the minimum gross premiums derived in sub-subparagraph a.

c. Third, a determination should be made of the amount of actual premium payments in excess of the minimum gross premiums. For policies utilizing shadow accounts, this will be the amount of the shadow account. For policies with no shadow accounts but which specify cumulative premium requirements, this excess will be the amount of the cumulative premiums paid in excess of the cumulative premium requirements; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee).

d. Fourth, a determination should be made of the single payment necessary at the valuation date to fully fund the remaining secondary guarantee assuming that the minimum gross premiums have been paid, up through the valuation date, during the secondary guarantee period. The result from sub-subparagraph c. should be divided by this number.

e. Fifth, compute the net single premium on the valuation date for the coverage provided by the secondary guarantee for the remainder of the secondary guarantee period, using any valuation table and select factors authorized in paragraph (5)(a) of Rule 69O-164.020, F.A.C.

f. Sixth, the "net amount of additional premiums" is determined by multiplying the ratio from sub-subparagraph d. by the difference between the net single premium from sub-subparagraph e. and the basic and deficiency reserve, if any, computed in sub-subparagraph b.

g. Seventh, a "reduced deficiency reserve" should be computed by multiplying the deficiency reserve, if any, by one minus the ratio from sub-subparagraph d., but not less than zero. This "reduced deficiency reserve" is the deficiency reserve to be used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C.

h. Eighth, the actual reserve used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C., is the lesser of: (1) the net single premium from sub-subparagraph e., and (2) the amount of the excess from sub-subparagraph f., plus the basic reserve and the deficiency reserve, if any, computed in sub-subparagraph b. Reduce this result by the applicable policy surrender charges, i.e., the account value less the cash surrender value. If the resulting amount is less than the sum of the basic and deficiency reserve from sub-subparagraph b., then the basic and deficiency reserves to be used for the purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C., are those calculated in sub-subparagraph b., and no further calculation is required.

i. Ninth, an "increased basic reserve" should be computed by subtracting the "reduced deficiency reserve" in sub-subparagraph g. from the reserve computed in sub-subparagraph h. This "increased basic reserve" is the basic reserve to be used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C.

2. For policies and certificates issued on or after July 1, 2005, and prior to January 1, 2007:

a. First, the minimum gross premiums (determined at issue) that will satisfy the secondary guarantee requirement must be derived.

b. Second, for purposes of applying paragraphs (7)(b) and (7)(c) of Rule 69O-164.020, F.A.C., the "specified premiums" are the minimum gross premiums derived in sub-subparagraph a. consistent with Rule 69O-164.020, F.A.C., the remaining sub-subparagraphs in this rule should be calculated on a segmented basis, using the segments that Rule 69O-164.020, F.A.C., defines for the product. Therefore, in the remaining sub-subparagraphs, the term "fully fund the guarantee" should be interpreted to mean fully funding the guarantee to the end of each possible segment. The term "remainder of the secondary guarantee period" should be interpreted to mean the remainder of each possible segment. The total reserve should equal the greatest of all possible segmented reserves.

c. Third, a determination should be made of the amount of actual premium payments in excess of the minimum gross premiums. For policies utilizing shadow accounts, this will be the amount of the shadow account. For policies with no shadow accounts but which specify cumulative premium requirements, this excess will be the amount of the cumulative premiums paid in excess of the cumulative premium requirements; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee).

d. Fourth, as of the valuation date for the policy being valued, for policies utilizing shadow accounts, determine the minimum amount of shadow account required to fully fund the guarantee. For policies with no shadow accounts but which specify cumulative premium requirements, determine the amount of the cumulative premiums paid in excess of the cumulative premium requirements that would result in no future premium requirements to fully fund the guarantee; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee). For any policy for which the secondary guarantee can not be fully funded in advance, solve for the minimum sum of any possible excess funding (either the amount in the shadow account or excess cumulative premium payments depending on the product design) and the present value of future premiums (using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves) that would fully fund the guarantee. The amount determined above for this sub-subparagraph is to then be divided by one minus a seven percent premium load allowance (0.93). The result from sub-subparagraph c. should be divided by this number, with the resulting ratio capped at 1. The ratio is intended to measure the level of prefunding for a secondary guarantee which is used to establish reserves. Assumptions within the numerator and denominator of the ratio therefore must be consistent in order to appropriately reflect the level of prefunding. The denominator is allowed to be inconsistent only by the amount of the premium load allowance as defined in this sub-subparagraph. As used here, "assumptions" include any factor or value, whether assumed or known, which is used to calculate the numerator or denominator of the ratio.

e. Fifth, compute the net single premium on the valuation date for the coverage provided by the secondary guarantee for the remainder of the secondary guarantee period, using any valuation table and select factors authorized in paragraph (5)(a) of Rule 69O-164.020, F.A.C.

f. Sixth, the "net amount of additional premiums" is determined by multiplying the ratio from sub-subparagraph d. by the difference between the net single premium from sub-subparagraph e. and the basic and deficiency reserve, if any, computed in sub-subparagraph b.

g. Seventh, a "reduced deficiency reserve" should be computed by multiplying the deficiency reserve, if any, by one minus the ratio from sub-subparagraph d., but not less than zero. This "reduced deficiency reserve" is the deficiency reserve to be used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C.

h. Eighth, the actual reserve used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C., is the lesser of: (1) the net single premium from sub-subparagraph e., and (2) the amount of the excess from sub-subparagraph f. plus the basic reserve and the deficiency reserve, if any, computed in sub-subparagraph b. Reduce this result by the applicable policy surrender charges, i.e., the account value less the cash surrender value. Multiply the applicable policy surrender charge by the ratio of the net level premium for the secondary guarantee period divided by the net level premium for whole life insurance. Calculate both net premiums using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves. However, if no future premiums are required to support the guarantee period being valued, there is no reduction for surrender charges. If the resulting amount is less than the sum of the basic and deficiency reserve from sub-subparagraph b., then the basic and deficiency reserves to be used for the purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C., are those calculated in sub-subparagraph b., and no further calculation is required.

i. Ninth, an "increased basic reserve" should be computed by subtracting the "reduced deficiency reserve" in sub-subparagraph g. from the reserve computed in sub-subparagraph h. This "increased basic reserve" is the basic reserve to be used for purposes of subparagraph 69O-164.020(7)(d)1., F.A.C.

3. For policies and certificates issued on or after January 1, 2007, and prior to January 1, 2011:

a. First, the minimum gross premiums (determined at issue) that will satisfy the secondary guarantee requirement must be derived.

b. Second, for purposes of applying paragraphs (7)(b) and (7)(c) of Rule 69O-164.020, F.A.C., the "specified premiums" are the minimum gross premiums derived in sub-subparagraph a.

(I) Consistent with Rule 69O-164.020, F.A.C., the remaining sub-subparagraphs in this rule should be calculated on a segmented basis, using the segments that Rule 69O-164.020, F.A.C., defines for the product. Therefore, in the remaining sub-subparagraphs, the term "fully fund the guarantee" should be interpreted to mean fully funding the guarantee to the end of each possible segment. The term "remainder of the secondary guarantee period" should be interpreted to mean the remainder of each possible segment. The total reserve should equal the greatest of all possible segmented reserves.

(II) Additionally, for purposes of applying paragraphs (7)(b) and (c) of Rule 69O-164.020, F.A.C., a lapse rate of no more than 2% per year for the first 5 years, followed by no more than 1% per year to the policy anniversary specified in the following table based on issue age, and 0% per year thereafter may be used. If the duration in the table is less than 5, then a lapse rate of no more than 2% per year may be used through that duration, and 0% per year thereafter.

Issue Age	Duration
0 – 50	30th Policy Anniversary
51 – 60	Policy Anniversary Age 80
61 – 70	20th Policy Anniversary
71 – 89	Policy Anniversary Age 90
90 and over	No Lapse

c. Third, a determination should be made of the amount of actual premium payments in excess of the minimum gross premiums. For policies utilizing shadow accounts, this will be the amount of the shadow account. For policies with no shadow accounts but which specify cumulative premium requirements, this excess will be the amount of the cumulative premiums paid in excess of the cumulative premium requirements; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee).

d. Fourth, as of the valuation date for the policy being valued, for policies utilizing shadow accounts, determine the minimum amount of shadow account required to fully fund the guarantee. For policies with no shadow accounts but which specify cumulative premium requirements, determine the amount of the cumulative premiums paid in excess of the cumulative premium requirements that would result in no future premium requirements to fully fund the guarantee; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee). For any policy for which the secondary guarantee cannot be fully funded in advance, solve for the minimum sum of any possible excess funding (either the amount in the shadow account or excess cumulative premium payments depending on the product design) and the present value of future premiums (using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves) that would fully fund the guarantee. The amount determined above for this sub-subparagraph is to then be divided by one minus a seven percent premium load allowance (0.93). The result from sub-subparagraph c. should be divided by this number, with the resulting ratio capped at 1. The ratio is intended to measure the level of prefunding for a secondary guarantee which is used to establish reserves. Assumptions within the numerator and denominator of the ratio therefore must be consistent in order to appropriately reflect the level of prefunding. The denominator is allowed to be inconsistent only by the amount of the premium load allowance as defined in this sub-subparagraph. As used here, "assumptions" include any factor or value, whether assumed or known, which is used to calculate the numerator or denominator of the ratio.

e. Fifth, compute the net single premium on the valuation date for the coverage provided by the secondary guarantee for the remainder of the secondary guarantee period, using any valuation table and select factors authorized in paragraph (5)(a) of Rule 69O-164.020, F.A.C. For purposes of calculating the net single premium, a lapse rate subject to the same criteria as the lapse rate used in applying paragraph b. above may be used.

f. Sixth, the "net amount of additional premiums" is determined by multiplying the ratio from sub-subparagraph d. by the difference between the net single premium from sub-subparagraph e. and the basic and deficiency reserve, if any, computed in sub-subparagraph b.

g. Seventh, a "reduced deficiency reserve" should be computed by multiplying the deficiency reserve, if any, by one minus the ratio from sub-subparagraph d., but not less than zero. This "reduced deficiency reserve" is the deficiency reserve to be used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C.

h. Eighth, the actual reserve used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C., is the lesser of: (1) the net single premium from sub-subparagraph e., and (2) the amount of the excess from sub-subparagraph f., plus the basic reserve and the deficiency reserve, if any, computed in sub-subparagraph b.

(I) Reduce this result by the applicable policy surrender charges, i.e., the account value less the cash surrender value.

(II) Multiply the applicable policy surrender charge by the ratio of the net level premium for the secondary guarantee period divided by the net level premium for whole life insurance.

(III) Calculate both net premiums using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves. However, if no future premiums are required to support the guarantee period being valued, there is no reduction for surrender charges.

(IV) Multiply this surrender charge by the ratio of the net level premium for the secondary guarantee period divided by the net level premium for whole life insurance. Calculate both net premiums using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves.

(V) If the resulting amount is less than the sum of the basic and deficiency reserve from sub-subparagraph b., then the basic and deficiency reserves to be used for the purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C., are those calculated in sub-subparagraph b., and no further calculation is required.

i. Ninth, an "increased basic reserve" should be computed by subtracting the "reduced deficiency reserve" in sub-subparagraph g. from the reserve computed in sub-subparagraph h. This "increased basic reserve" is the basic reserve to be used for purposes of subparagraph 69O-164.020(7)(d)1., F.A.C.

j. Business reserved pursuant to (2)(i)3. of this rule must be supported by an asset adequacy analysis specific to this business.

(I) This asset adequacy analysis must be performed pursuant to the requirements of Section 625.121(3), FS.

(II) Reserves required by subparagraph (2)(i)3. of this rule, plus any additional reserves required by the asset adequacy analysis, shall be the minimum reserves for this business.

(3) Effective Date.

(a) The application of this rule shall be to policies issued on or after December 24, 2003.

(b) Subparagraph (2)(i)2. shall apply to all policies and certificates issued on or after July 1, 2005.

Specific Authority 624.308(1), 625.121(5) FS. Law Implemented 624.307(1), 625.121(5) FS. History–New 5-4-06, Amended 1-16-08.

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.

625.121 Standard Valuation Law; life insurance.—

(5) MINIMUM STANDARD FOR VALUATION OF POLICIES AND CONTRACTS ISSUED ON OR AFTER OPERATIVE DATE OF STANDARD NONFORFEITURE LAW.—Except as otherwise provided in paragraph (h) and subsections (6), (11), and (14), the minimum standard for the valuation of all such policies and contracts issued on or after the operative date of s. 627.476 (Standard Nonforfeiture Law for Life Insurance) shall be the commissioners' reserve valuation method defined in subsections (7), (11), and (14); 5 percent interest for group annuity and pure endowment contracts and 3.5 percent interest for all other such policies and contracts, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after July 1, 1973, 4 percent interest for such policies issued prior to October 1, 1979, and 4.5 percent interest for such policies issued on or after October 1, 1979; and the following tables:

(a) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies:

1. For policies issued prior to the operative date of s. 627.476(9), the commissioners' 1958 Standard Ordinary Mortality Table; except that, for any category of such policies issued on female risks, modified net premiums and present values, referred to in subsection (7), may be calculated according to an age not more than 6 years younger than the actual age of the insured.

2. For policies issued on or after the operative date of s. 627.476(9), the commissioners' 1980 Standard Ordinary Mortality Table or, at the election of the insurer for any one or more specified plans of life insurance, the commissioners' 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors.

3. For policies issued on or after July 1, 2004, ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for such policies.

(b) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies:

1. For policies issued prior to the first date to which the commissioners' 1961 Standard Industrial Mortality Table is applicable according to s. 627.476, the 1941 Standard Industrial Mortality Table; and

2. For such policies issued on or after that date, the commissioners' 1961 Standard Industrial Mortality Table.

(c) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 Standard Annuity Mortality Table or, at the option of the insurer, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the office.

(d) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the Group Annuity Mortality Table for 1951; any modification of such table approved by the office; or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts:

1. For policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the Society of Actuaries, with due regard to the type of benefit;

2. For policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either those tables or, at the option of the insurer, the class three disability table (1926);
3. For policies issued prior to January 1, 1961, the class three disability table (1926); and
4. For policies or contracts issued on or after July 1, 2004, tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for those policies or contracts.

Any such table for active lives shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies:
1. For policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table;
2. For policies issued on or after January 1, 1961, and prior to January 1, 1966, either that table or, at the option of the insurer, the Intercompany Double Indemnity Mortality Table;
3. For policies issued prior to January 1, 1961, the Intercompany Double Indemnity Mortality Table; and
4. For policies issued on or after July 1, 2004, tables of accidental death benefits adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for those policies.

Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(g) For group life insurance, life insurance issued on the substandard basis, and other special benefits, such tables as may be approved by the office as being sufficient with relation to the benefits provided by such policies.
(h) Except as provided in subsection (6), the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this paragraph and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts shall be the commissioners' reserve valuation method defined in subsection (7) and the following tables and interest rates:
1. For individual annuity and pure endowment contracts issued prior to October 1, 1979, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the office, and 6 percent interest for single-premium immediate annuity contracts and 4 percent interest for all other individual annuity and pure endowment contracts.
2. For individual single-premium immediate annuity contracts issued on or after October 1, 1979, and prior to October 1, 1986, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the office, and 7.5 percent interest. For such contracts issued on or after October 1, 1986, the 1983 Individual Annual Mortality Table, or any modification of such table approved by the office, and the applicable calendar year statutory valuation interest rate as described in subsection (6).
3. For individual annuity and pure endowment contracts issued on or after October 1, 1979, and prior to October 1, 1986, other than single-premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the office, and 5.5 percent interest for single-premium deferred annuity and pure endowment

contracts and 4.5 percent interest for all other such individual annuity and pure endowment contracts. For such contracts issued on or after October 1, 1986, the 1983 Individual Annual Mortality Table, or any modification of such table approved by the office, and the applicable calendar year statutory valuation interest rate as described in subsection (6).

4. For all annuities and pure endowments purchased prior to October 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any modification of this table approved by the office, and 6 percent interest.
5. For all annuities and pure endowments purchased on or after October 1, 1979, and prior to October 1, 1986, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any modification of this table approved by the office, and 7.5 percent interest. For such contracts purchased on or after October 1, 1986, the 1983 Group Annuity Mortality Table, or any modification of such table approved by the office, and the applicable calendar year statutory valuation interest rate as described in subsection (6).

After July 1, 1973, any insurer may have filed with the former Department of Insurance a written notice of its election to comply with the provisions of this paragraph after a specified date before January 1, 1979, which shall be the operative date of this paragraph for such insurer. However, an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no such election, the operative date of this paragraph for such insurer shall be January 1, 1979.

(i) In lieu of the mortality tables specified in this subsection, and subject to rules previously adopted by the former Department of Insurance, the insurance company may, at its option:

1. Substitute the applicable 1958 CSO or CET Smoker and Nonsmoker Mortality Tables, in lieu of the 1980 CSO or CET mortality table standard, for policies issued on or after the operative date of s. 627.476(9) and before January 1, 1989.
2. Substitute the applicable 1980 CSO or CET Smoker and Nonsmoker Mortality Tables in lieu of the 1980 CSO or CET mortality table standard;
3. Use the Annuity 2000 Mortality Table for determining the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after January 1, 1998, and before July 1, 1998.
4. Use the 1994 GAR Table for determining the minimum standard of valuation for annuities and pure endowments purchased on or after January 1, 1998, and before July 1, 1998, under group annuity and pure endowment contracts.

(j) The commission may adopt by rule the model regulation for valuation of life insurance policies as approved by the National Association of Insurance Commissioners in March 1999, including tables of select mortality factors, and may make the regulation effective for policies issued on or after January 1, 2000.

(k) For individual annuity and pure endowment contracts issued on or after July 1, 2004, excluding any disability and accidental death benefits purchased under those contracts, individual annuity mortality tables adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for those contracts.

(l) For all annuities and pure endowments purchased on or after July 1, 2004, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts, group annuity mortality tables adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for those contracts.

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 15, 2012

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Bob Prentiss

SUBJECT: Cabinet Agenda for June 26, 2012
Request for Approval to Publish Repeal to Rules:

69O-198.003; License Required

69O-200.013; Rate Filings

69O-170.012; Sinkhole Insurance

69O-191.072; Reinsurance (Excess Loss Insurance)

The Office of Insurance Regulation requests that these proposed rule repeals be presented to the Cabinet aides on or before June 20, 2012 and to the Financial Services Commission on June 26, 2012, with a request to approve for publication the proposed rule repeals.

These rules are being repealed because the laws that they were adopted to implement have been repealed or they substantially restate language contained in the Florida Insurance Code.

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

Approved for signature:

Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-198.003 License Required.

Specific Authority 634.402 FS. Law Implemented 634.403. History–New 3-28-93, Formerly 4-198.003, Repealed.

690-198.003 License Required.

No person, entity or administrator in this state shall provide or offer to provide service warranties unless authorized therefor under a subsisting license issued by the Office.

Specific Authority 634.402 FS. Law Implemented 634.403. History–New 3-28-93, Formerly 4-198.003.

69O-200.013 Rate Filings.

Specific Authority 634.021 FS. Law Implemented 634.1216 FS. History–New 5-26-93, Formerly 4-200.01, Repealed.

69O-200.013 Rate Filings.

(1) The rating manuals that shall be filed with the Office shall include a copy of all rates to be charged the consumer and service agreement forms (with the Office's approval stamp affixed) currently in use.

(2) It shall be the company's responsibility to continually update their rating manuals.

Specific Authority 634.021 FS. Law Implemented 634.1216 FS. History–New 5-26-93, Formerly 4-200.013.

69O-170.012 Sinkhole Insurance.

Specific Authority 624.308(1) FS. Law Implemented Sec. 4, House Bill 89-B, Special Session B (1993), Ch. 92-146, Sec. 2, Laws of Florida, 624.307(1), 626.9541, 626.9641, 627.4133, 627.706 FS. History–New 9-29-92, Amended 9-8-93, Formerly 4-170.012 Repealed.

69O-170.012 Sinkhole Insurance.

(1) No insurer may nonrenew or cancel any property insurance policy "on the basis of filing of claims for partial loss caused by sinkhole damage or clay shrinkage".

(2) Subsection (1) of this rule applies regardless of whether the policy in question has been the subject of a sinkhole or clay shrinkage claim. If a sinkhole or clay shrinkage claim, or the risk associated with the occurrence of such a claim, is the basis of such contemplated cancellation or nonrenewal, subsection (1) of this rule applies. However, an insurer may nonrenew or cancel a policy if the total of claim payments for that policy exceed the current policy limits of coverage for property damage, or if the insured has failed to repair the structure in accordance with the engineering recommendations upon which any payment or policy proceeds were based.

Specific Authority 624.308(1) FS. Law Implemented Sec. 4, House Bill 89-B, Special Session B (1993), Ch. 92-146, Sec. 2, Laws of Florida, 624.307(1), 626.9541, 626.9641, 627.4133, 627.706 FS. History–New 9-29-92, Amended 9-8-93, Formerly 4-170.012.

69O-191.072 Reinsurance (Excess Loss Insurance).

Specific Authority 641.36 FS. Law Implemented 641.285(5)(a)1. FS. History–New 2-22-88, Amended 10-25-89, Formerly 4-31.072, Amended 5-28-92, Formerly 4-191.072, Repealed.

69O-191.072 Reinsurance (Excess Loss Insurance).

HMOs may ~~obtain~~ reinsurance (excess loss insurance) in order to limit the HMO's financial risk. All excess loss or reinsurance contracts shall be filed with and ~~approved~~ by the Office. In addition to the regular insurance filing of any reinsurance (excess loss insurance) contract, if the reinsurance (excess loss ~~insurance~~) contract contains insolvency protection for the HMO, the contract shall be submitted for prior approval to the Bureau of Specialty Insurers, ~~Office of~~ Insurance Regulation, Tallahassee, Florida 32399-0300.

Specific Authority 641.36 FS. Law Implemented 641.285(5)(a)1. FS. History–New 2-22-88, Amended 10-25-89, Formerly 4-31.072, Amended 5-28-92, Formerly 4-191.072.

690-198.003
Rulemaking Authority

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) anc 120.54 to implement provisions of this part related to sales representatives. Such rules by the commissior 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.

634.403 License required; exemptions.—

(1) No person in this state shall provide or offer to provide service warranties to residents of this state unless authorized therefor under a subsisting license issued by the office. The service warranty association shall pay to the office a license fee of $200 for such license for each license year, or part thereof, the license is in force.

(2) An insurer, while authorized to transact property or casualty insurance in this state, may also transact a service warranty business without additional qualifications or authority, but shall be otherwise subject to the applicable provisions of this part.

(3) The office may, pursuant to s. 120.569, in its discretion and without advance notice and hearing, issue an immediate final order to cease and desist to any person or entity which violates this section. The Legislature finds that a violation of this section constitutes an imminent and immediate threat to the public health, safety, and welfare of the residents of this state.

(4) Any person that is an affiliate of a domestic insurer as defined in chapter 624 is exempt from application of this part if the person does not issue, or market or cause to be marketed, service warranties to residents of this state and does not administer service warranties that were originally issued to residents of this state. The domestic insurer or its wholly owned Florida licensed insurer must be the direct obligor of all service warranties issued by such affiliate or must issue a contractual liability insurance policy to such affiliate that meets the conditions described in s. 634.406(3). If the Office of Insurance Regulation determines, after notice and opportunity for a hearing, that a person's intentional business practices do not comply with any of the exemption requirements of this subsection, the person shall be subject to this part.

(5) A person is exempt from the license requirement in this section if the person complies with the following:

(a) The service warranties are only sold to nonresidents of this state and the person does not issue, market, or cause to be marketed service warranties to residents of this state.

(b) The person submits a letter of notification that provides the following information to the office upon the start of business from this state and annually thereafter by March 1:

1. The type of products offered and a statement certifying that the products are not regulated in the state in which the person is transacting business or that the person is licensed in the state in which the person is transacting business.

2. The name of the person; the state of domicile; the home address and address in this state of the person; the names of the owners and their percentage of ownership; the names of the officers and directors; the name, e-mail, and telephone number of a contact person; the states in which the person is transacting business; and how many individuals are employed in this state.

(c) If the person ceases to do business from this state, the person shall provide written notification to the office within 30 days after cessation of business.

(6) Any person who provides, offers to provide, or holds oneself out as providing or offering to provide a service warranty to residents of this state without holding a subsisting license commits, in addition to any other violation, a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

690-200.013
Rulemaking Authority

634.021 Powers of department, commission, and office; rules.—The office shall administer this act and commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this 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.

634.1216 Rate filings.—Each insurer and each motor vehicle service agreement company shall file with t office the rates, rating schedules, or rating manuals used, including all modifications of rates and premiums, to be paid by the service agreement holder. Every filing shall state the proposed effective dat thereon. The filing shall be made not less than 30 days before its effective date.

69O-170.012
Rulemaking Authority

624.308 Rules.—

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

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:

(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, or comparison 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.

(b) False information and advertising generally.—Knowingly 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:

1. In a newspaper, magazine, or other publication,
2. In the form of a notice, circular, pamphlet, letter, or poster,
3. Over any radio or television station, or
4. In any other way,

an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, which is untrue, deceptive, or misleading.

(c) Defamation.—Knowingly making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of, any oral or written statement, or any pamphlet, circular, article, or literature, which is false or maliciously critical of, or derogatory to, any person and which is calculated to injure such person.

(d) Boycott, coercion, and intimidation.—Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in, or tending to result in, unreasonable restraint of, or monopoly in, the business of insurance.

(e) False statements and entries.—

1. Knowingly:

a. Filing with any supervisory or other public official,

b. Making, publishing, disseminating, circulating,

c. Delivering to any person,

d. Placing before the public,

e. Causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public,

any false material statement.

2. Knowingly making any false entry of a material fact in any book, report, or statement of any person, or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report, or statement of such person.

(f) Stock operations and advisory board contracts.—Issuing or delivering, promising to issue or deliver, or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns or profits as an inducement to insurance.

(g) Unfair discrimination.—

1. Knowingly making or permitting any unfair discrimination between individuals of the same actuarially supportable class and equal expectation of life, in the rates charged for any life insurance or annuity contract, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

2. Knowingly making or permitting any unfair discrimination between individuals of the same actuarially supportable class, as determined at the original time of issuance of the coverage, and essentially the same hazard, in the amount of premium, policy fees, or rates charged for any policy or contract of accident, disability, or health insurance, in the benefits payable thereunder, in any of the terms or conditions of such contract, or in any other manner whatever.

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 shall 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 does not constitute an act of unfair discrimination as defined in this paragraph.

(h) Unlawful rebates.—

1. Except as otherwise expressly provided by law, or in an applicable filing with the office, knowingly:

a. Permitting, or offering to make, or making, any contract or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon;

b. Paying, allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance contract, any unlawful rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract;

c. Giving, selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance contract or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the insurance contract.

2. Nothing in paragraph (g) or subparagraph 1. of this paragraph shall be construed as including within the definition of discrimination or unlawful rebates:

a. In the case of any contract of life insurance or life annuity, paying bonuses to all policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided that any such bonuses or abatement of premiums is fair and equitable to all policyholders and for the best interests of the company and its policyholders.

b. In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses.

c. Readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

d. Issuance of life insurance policies or annuity contracts at rates less than the usual rates of premiums for such policies or contracts, as group insurance or employee insurance as defined in this code.

e. Issuing life or disability insurance policies on a salary savings, bank draft, preauthorized check, payroll deduction, or other similar plan at a reduced rate reasonably related to the savings made by the use of such plan.

3.a. No title insurer, or any member, employee, attorney, agent, or agency thereof, shall pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as inducement to title insurance, or after such insurance has been effected, any rebate or abatement of the premium or any other charge or fee, or provide any special favor or advantage, or any monetary consideration or inducement whatever.

b. Nothing in this subparagraph shall be construed as prohibiting the payment of fees to attorneys at law duly licensed to practice law in the courts of this state, for professional services, or as prohibiting the payment of earned portions of the premium to duly appointed agents or agencies who actually perform services for the title insurer. Nothing in this subparagraph shall be construed as prohibiting a rebate or abatement of an attorney's fee charged for professional services, or that portion of the premium that is not required to be retained by the insurer pursuant to s. 627.782(1), or any other agent charge or fee to the person responsible for paying the premium, charge, or fee.

c. No insured named in a policy, or any other person directly or indirectly connected with the transaction involving the issuance of such policy, including, but not limited to, any

mortgage broker, real estate broker, builder, or attorney, any employee, agent, agency, or representative thereof, or any other person whatsoever, shall knowingly receive or accept, directly or indirectly, any rebate or abatement of any portion of the title insurance premium or of any other charge or fee or any monetary consideration or inducement whatsoever, except as set forth in sub-subparagraph b.; provided, in no event shall any portion of the attorney's fee, any portion of the premium that is not required to be retained by the insurer pursuant to s. 627.782(1), any agent charge or fee, or any other monetary consideration or inducement be paid directly or indirectly for the referral of title insurance business.

(i) Unfair claim settlement practices.—

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;

2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy; or

3. Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Failing to adopt and implement standards for the proper investigation of claims;

b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

c. Failing to acknowledge and act promptly upon communications with respect to claims;

d. Denying claims without conducting reasonable investigations based upon available information;

e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed;

f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;

g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or

h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

4. Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed.

(j) Failure to maintain complaint-handling procedures.—Failure of any person to maintain a complete record of all the complaints received since the date of the last examination. For purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance.

(k) Misrepresentation in insurance applications.—

1. Knowingly making a false or fraudulent written or oral statement or representation on, or relative to, an application or negotiation for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual.

2. Knowingly making a material omission in the comparison of a life, health, or Medicare supplement insurance replacement policy with the policy it replaces for the purpose of

obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual. For the purposes of this subparagraph, a material omission includes the failure to advise the insured of the existence and operation of a preexisting condition clause in the replacement policy.

(l) Twisting.—Knowingly making any misleading representations or incomplete or fraudulent comparisons or fraudulent material omissions of or with respect to any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance in another insurer.

(m) Advertising gifts permitted.—No provision of paragraph (f), paragraph (g), or paragraph (h) shall be deemed to prohibit a licensed insurer or its agent from giving to insureds, prospective insureds, and others, for the purpose of advertising, any article of merchandise having a value of not more than $25.

(n) Free insurance prohibited.—

1. Advertising, offering, or providing free insurance as an inducement to the purchase or sale of real or personal property or of services directly or indirectly connected with such real or personal property.

2. For the purposes of this paragraph, "free" insurance is:

a. Insurance for which no identifiable and additional charge is made to the purchaser of such real property, personal property, or services.

b. Insurance for which an identifiable or additional charge is made in an amount less than the cost of such insurance as to the seller or other person, other than the insurer, providing the same.

3. Subparagraphs 1. and 2. do not apply to:

a. Insurance of, loss of, or damage to the real or personal property involved in any such sale or services, under a policy covering the interests therein of the seller or vendor.

b. Blanket disability insurance as defined in s. 627.659.

c. Credit life insurance or credit disability insurance.

d. Any individual, isolated, nonrecurring unadvertised transaction not in the regular course of business.

e. Title insurance.

f. Any purchase agreement involving the purchase of a cemetery lot or lots in which, under stated conditions, any balance due is forgiven upon the death of the purchaser.

g. Life insurance, trip cancellation insurance, or lost baggage insurance offered by a travel agency as part of a travel package offered by and booked through the agency.

4. Using the word "free" or words which imply the provision of insurance without a cost to describe life or disability insurance, in connection with the advertising or offering for sale of any kind of goods, merchandise, or services.

(o) Illegal dealings in premiums; excess or reduced charges for insurance.—

1. Knowingly collecting any sum as a premium or charge for insurance, which is not then provided, or is not in due course to be provided, subject to acceptance of the risk by the insurer, by an insurance policy issued by an insurer as permitted by this code.

2. Knowingly collecting as a premium or charge for insurance any sum in excess of or less than the premium or charge applicable to such insurance, in accordance with the applicable classifications and rates as filed with and approved by the office, and as specified in the policy; or, in cases when classifications, premiums, or rates are not required by this code to be so filed and approved, premiums and charges collected from a Florida resident in excess of or less than those specified in the policy and as fixed by the insurer. This provision shall not be deemed to prohibit the charging and collection, by surplus lines agents licensed under part VIII of this chapter, of the amount of applicable state and federal taxes, or fees as authorized by s. 626.916(4), in addition to the premium required by the insurer or the charging and collection, by licensed agents, of the exact amount of any discount or other such fee charged by a credit card facility in connection with the use of a credit card, as

authorized by subparagraph (q)3., in addition to the premium required by the insurer. This subparagraph shall not be construed to prohibit collection of a premium for a universal life or a variable or indeterminate value insurance policy made in accordance with the terms of the contract.

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.

b. An insurer which imposes and collects such a surcharge or which refuses to renew such policy shall, in conjunction with the notice of premium due or notice of nonrenewal, notify the named insured that he or she is entitled to reimbursement of such amount or renewal of the policy under the conditions listed below and will subsequently reimburse him or her or renew the policy, if the named insured demonstrates that the operator involved in the accident was:

(I) Lawfully parked;

(II) Reimbursed by, or on behalf of, a person responsible for the accident or has a judgment against such person;

(III) Struck in the rear by another vehicle headed in the same direction and was not convicted of a moving traffic violation in connection with the accident;

(IV) Hit by a "hit-and-run" driver, if the accident was reported to the proper authorities within 24 hours after discovering the accident;

(V) Not convicted of a moving traffic violation in connection with the accident, but the operator of the other automobile involved in such accident was convicted of a moving traffic violation;

(VI) Finally adjudicated not to be liable by a court of competent jurisdiction;

(VII) In receipt of a traffic citation which was dismissed or nolle prossed; or

(VIII) Not at fault as evidenced by a written statement from the insured establishing facts demonstrating lack of fault which are not rebutted by information in the insurer's file from which the insurer in good faith determines that the insured was substantially at fault.

c. In addition to the other provisions of this subparagraph, an insurer may not fail to renew a policy if the insured has had only one accident in which he or she was at fault within the current 3-year period. However, an insurer may nonrenew a policy for reasons other than accidents in accordance with s. 627.728. This subparagraph does not prohibit nonrenewal of a policy under which the insured has had three or more accidents, regardless of fault, during the most recent 3-year period.

4. Imposing or requesting an additional premium for, or refusing to renew, a policy for motor vehicle insurance solely because the insured committed a noncriminal traffic infraction as described in s. 318.14 unless the infraction is:

a. A second infraction committed within an 18-month period, or a third or subsequent infraction committed within a 36-month period.

b. A violation of s. 316.183, when such violation is a result of exceeding the lawful speed limit by more than 15 miles per hour.

5. Upon the request of the insured, the insurer and licensed agent shall supply to the insured the complete proof of fault or other criteria which justifies the additional charge or cancellation.

6. No insurer shall impose or request an additional premium for motor vehicle insurance, cancel or refuse to issue a policy, or refuse to renew a policy because the insured or the applicant is a handicapped or physically disabled person, so long as such handicap or physical disability does not substantially impair such person's mechanically assisted driving ability.

7. No insurer may cancel or otherwise terminate any insurance contract or coverage, or require execution of a consent to rate endorsement, during the stated policy term for the

purpose of offering to issue, or issuing, a similar or identical contract or coverage to the same insured with the same exposure at a higher premium rate or continuing an existing contract or coverage with the same exposure at an increased premium.

8. No insurer may issue a nonrenewal notice on any insurance contract or coverage, or require execution of a consent to rate endorsement, for the purpose of offering to issue, or issuing, a similar or identical contract or coverage to the same insured at a higher premium rate or continuing an existing contract or coverage at an increased premium without meeting any applicable notice requirements.

9. No insurer shall, with respect to premiums charged for motor vehicle insurance, unfairly discriminate solely on the basis of age, sex, marital status, or scholastic achievement.

10. Imposing or requesting an additional premium for motor vehicle comprehensive or uninsured motorist coverage solely because the insured was involved in a motor vehicle accident or was convicted of a moving traffic violation.

11. No insurer shall cancel or issue a nonrenewal notice on any insurance policy or contract without complying with any applicable cancellation or nonrenewal provision required under the Florida Insurance Code.

12. No insurer shall impose or request an additional premium, cancel a policy, or issue a nonrenewal notice on any insurance policy or contract because of any traffic infraction when adjudication has been withheld and no points have been assessed pursuant to s. 318.14(9) and (10). However, this subparagraph does not apply to traffic infractions involving accidents in which the insurer has incurred a loss due to the fault of the insured.

(p) Insurance cost specified in "price package".—

1. When the premium or charge for insurance of or involving such property or merchandise is included in the overall purchase price or financing of the purchase of merchandise or property, the vendor or lender shall separately state and identify the amount charged and to be paid for the insurance, and the classifications, if any, upon which based; and the inclusion or exclusion of the cost of insurance in such purchase price or financing shall not increase, reduce, or otherwise affect any other factor involved in the cost of the merchandise, property, or financing as to the purchaser or borrower.

2. This paragraph does not apply to transactions which are subject to the provisions of part I of chapter 520, entitled "The Motor Vehicle Sales Finance Act."

3. This paragraph does not apply to credit life or credit disability insurance which is in compliance with s. 627.681(4).

(q) Certain insurance transactions through credit card facilities prohibited.—

1. Except as provided in subparagraph 3., no person shall knowingly solicit or negotiate any insurance; seek or accept applications for insurance; issue or deliver any policy; receive, collect, or transmit premiums, to or for any insurer; or otherwise transact insurance in this state, or relative to a subject of insurance resident, located, or to be performed in this state, through the arrangement or facilities of a credit card facility or organization, for the purpose of insuring credit card holders or prospective credit card holders. The term "credit card holder" as used in this paragraph means any person who may pay the charge for purchases or other transactions through the credit card facility or organization, whose credit with such facility or organization is evidenced by a credit card identifying such person as being one whose charges the credit card facility or organization will pay, and who is identified as such upon the credit card either by name, account number, symbol, insignia, or any other method or device of identification. This subparagraph does not apply as to health insurance or to credit life, credit disability, or credit property insurance.

2. Whenever any person does or performs in this state any of the acts in violation of subparagraph 1. for or on behalf of any insurer or credit card facility, such insurer or credit card facility shall be held to be doing business in this state and, if an insurer, shall be subject to the same state, county, and municipal taxes as insurers that have been legally qualified and admitted to do business in this state by agents or otherwise are subject, the

same to be assessed and collected against such insurers; and such person so doing or performing any of such acts shall be personally liable for all such taxes.

3. A licensed agent or insurer may solicit or negotiate any insurance; seek or accept applications for insurance; issue or deliver any policy; receive, collect, or transmit premiums, to or for any insurer; or otherwise transact insurance in this state, or relative to a subject of insurance resident, located, or to be performed in this state, through the arrangement or facilities of a credit card facility or organization, for the purpose of insuring credit card holders or prospective credit card holders if:

a. The insurance or policy which is the subject of the transaction is noncancelable by any person other than the named insured, the policyholder, or the insurer;

b. Any refund of unearned premium is made directly to the credit card holder; and

c. The credit card transaction is authorized by the signature of the credit card holder or other person authorized to sign on the credit card account.

The conditions enumerated in sub-subparagraphs a.-c. do not apply to health insurance or to credit life, credit disability, or credit property insurance; and sub-subparagraph c. does not apply to property and casualty insurance so long as the transaction is authorized by the insured.

4. No person may use or disclose information resulting from the use of a credit card in conjunction with the purchase of insurance, when such information is to the advantage of such credit card facility or an insurance agent, or is to the detriment of the insured or any other insurance agent; except that this provision does not prohibit a credit card facility from using or disclosing such information in any judicial proceeding or consistent with applicable law on credit reporting.

5. No such insurance shall be sold through a credit card facility in conjunction with membership in any 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, the definition of automobile clubs 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 race courses established and marked as such for the duration of such particular event. The words "motor vehicle" used herein shall be the same as defined in chapter 320.

(r) Interlocking ownership and management.—

1. Any domestic insurer may retain, invest in, or acquire the whole or any part of the capital stock of any other insurer or insurers, or have a common management with any other insurer or insurers, unless such retention, investment, acquisition, or common management is inconsistent with any other provision of this code, or unless by reason thereof the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business.

2. Any person otherwise qualified may be a director of two or more domestic insurers which are competitors, unless the effect thereof is substantially to lessen competition between insurers generally or materially tend to create a monopoly.

3. Any limitation contained in this paragraph does not apply to any person who is a director of two or more insurers under common control or management.

(s) Prohibited arrangements as to funerals.—

1. No life insurer shall designate in any life insurance policy the person to conduct the funeral of the insured, or organize, promote, or operate any enterprise or plan to enter into any contract with any insured under which the freedom of choice in the open market of the person having the legal right to such choice is restricted as to the purchase, arrangement, and conduct of a funeral service or any part thereof for any individual insured by the

insurer. No life insurer shall designate in any life insurance policy the person to conduct the funeral of the insured as the owner of the policy.

2. No insurer shall contract or agree to furnish funeral merchandise or services in connection with the disposition of any person upon the death of any person insured by such insurer.

3. No insurer shall contract or agree with any funeral director or direct disposer to the effect that such funeral director or direct disposer shall conduct the funeral of any person insured by such insurer.

4. No insurer shall provide, in any insurance contract covering the life of any person in this state, for the payment of the proceeds or benefits thereof in other than legal tender of the United States and of this state, or for the withholding of such proceeds or benefits, all for the purpose of either directly or indirectly providing, inducing, or furthering any arrangement or agreement designed to require or induce the employment of a particular person to conduct the funeral of the insured.

(t) Certain life insurance relations with funeral directors prohibited.—

1. No life insurer shall permit any funeral director or direct disposer to act as its representative, adjuster, claim agent, special claim agent, or agent for such insurer in soliciting, negotiating, or effecting contracts of life insurance on any plan or of any nature issued by such insurer or in collecting premiums for holders of any such contracts except as prescribed in s. 626.785(3).

2. No life insurer shall:

a. Affix, or permit to be affixed, advertising matter of any kind or character of any licensed funeral director or direct disposer to such policies of insurance.

b. Circulate, or permit to be circulated, any such advertising matter with such insurance policies.

c. Attempt in any manner or form to influence policyholders of the insurer to employ the services of any particular licensed funeral director or direct disposer.

3. No such insurer shall maintain, or permit its agent to maintain, an office or place of business in the office, establishment, or place of business of any funeral director or direct disposer in this state.

(u) False claims; obtaining or retaining money dishonestly.—

1. Any agent, physician, claimant, or other person who causes to be presented to any insurer a false claim for payment, knowing the same to be false; or

2. Any agent, collector, or other person who represents any insurer or collects or does business without the authority of the insurer, secures cash advances by false statements, or fails to turn over when required, or satisfactorily account for, all collections of such insurer,

shall, in addition to the other penalties provided in this act, be guilty of a misdemeanor of the second degree and, upon conviction thereof, shall be subject to the penalties provided by s. 775.082 or s. 775.083.

(v) Proposal required.—If a person simultaneously holds a securities license and a life insurance license, he or she shall prepare and leave with each prospective buyer a written proposal, on or before delivery of any investment plan. "Investment plan" means a mutual funds program, and the proposal shall consist of a prospectus describing the investment feature and a full illustration of any life insurance feature. The proposal shall be prepared in duplicate, dated, and signed by the licensee. The original shall be left with the prospect, the duplicate shall be retained by the licensee for a period of not less than 3 years, and a copy shall be furnished to the department upon its request. In lieu of a duplicate copy, a receipt for standardized proposals filed with the department may be obtained and held by the licensee.

(w) Soliciting or accepting new or renewal insurance risks by insolvent or impaired insurer prohibited; penalty.—

1. Whether or not delinquency proceedings as to the insurer have been or are to be initiated, but while such insolvency or impairment exists, no director or officer of an insurer, except with the written permission of the office, shall authorize or permit the insurer to solicit or accept new or renewal insurance risks in this state after such director or officer knew, or reasonably should have known, that the insurer was insolvent or impaired. "Impaired" includes impairment of capital or surplus, as defined in s. 631.011(12) and (13).

2. Any such director or officer, upon conviction of a violation of this paragraph, is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(x) Refusal to insure.—In addition to other provisions of this code, the refusal to insure, or continue to insure, any individual or risk solely because of:

1. Race, color, creed, marital status, sex, or national origin;

2. The residence, age, or lawful occupation of the individual or the location of the risk, unless there is a reasonable relationship between the residence, age, or lawful occupation of the individual or the location of the risk and the coverage issued or to be issued;

3. The insured's or applicant's failure to agree to place collateral business with any insurer, unless the coverage applied for would provide liability coverage which is excess over that provided in policies maintained on property or motor vehicles;

4. The insured's or applicant's failure to purchase noninsurance services or commodities, including automobile services as defined in s. 624.124;

5. The fact that the insured or applicant is a public official; or

6. The fact that the insured or applicant had been previously refused insurance coverage by any insurer, when such refusal to insure or continue to insure for this reason occurs with such frequency as to indicate a general business practice.

(y) Powers of attorney.—Except as provided in s. 627.842(2):

1. Requiring, as a condition to the purchase or continuation of an insurance policy, that an applicant for insurance or an insured execute a power of attorney in favor of an insurance agent or agency or employee thereof; or

2. Presenting to the applicant or the insured, as a routine business practice, a form that authorizes the insurance agent or agency to sign the applicant's or insured's name on any insurance-related document or application for the purchase of motor vehicle services as described in s. 624.124. To be valid, a power of attorney must be an act or practice other than as described in this paragraph, must be a separate writing in a separate document, must be executed with the full knowledge and consent of the applicant or insured who grants the power of attorney, must be in the best interests of the insured or applicant, and a copy of the power of attorney must be provided to the applicant or insured at the time of the transaction.

(z) Sliding.—Sliding is the act or practice of:

1. Representing to the applicant that a specific ancillary coverage or product is required by law in conjunction with the purchase of insurance when such coverage or product is not required;

2. Representing to the applicant that a specific ancillary coverage or product is included in the policy applied for without an additional charge when such charge is required; or

3. Charging an applicant for a specific ancillary coverage or product, in addition to the cost of the insurance coverage applied for, without the informed consent of the applicant.

[1](aa) Churning.—

1. Churning is the practice whereby policy values in an existing life insurance policy or annuity contract, including, but not limited to, cash, loan values, or dividend values, and in any riders to that policy or contract, are directly or indirectly used to purchase another insurance policy or annuity contract with that same insurer for the purpose of earning additional premiums, fees, commissions, or other compensation:

a. Without an objectively reasonable basis for believing that the replacement or extraction will result in an actual and demonstrable benefit to the policyholder;

b. In a fashion that is fraudulent, deceptive, or otherwise misleading or that involves a deceptive omission;

c. When the applicant is not informed that the policy values including cash values, dividends, and other assets of the existing policy or contract will be reduced, forfeited, or used in the purchase of the replacing or additional policy or contract, if this is the case; or

d. Without informing the applicant that the replacing or additional policy or contract will not be a paid-up policy or that additional premiums will be due, if this is the case.

Churning by an insurer or an agent is an unfair method of competition and an unfair or deceptive act or practice.

2. Each insurer shall comply with sub-subparagraphs 1.c. and 1.d. by disclosing to the applicant at the time of the offer on a form designed and adopted by rule by the commission if, how, and the extent to which the policy or contract values (including cash value, dividends, and other assets) of a previously issued policy or contract will be used to purchase a replacing or additional policy or contract with the same insurer. The form must include disclosure of the premium, the death benefit of the proposed replacing or additional policy, and the date when the policy values of the existing policy or contract will be insufficient to pay the premiums of the replacing or additional policy or contract.

3. Each insurer shall adopt written procedures to reasonably avoid churning of policies or contracts that it has issued, and failure to adopt written procedures sufficient to reasonably avoid churning shall be an unfair method of competition and an unfair or deceptive act or practice.

(bb) Deceptive use of name.—Using the name or logo of a financial institution, as defined in s. 655.005(1), or its affiliates or subsidiaries when marketing or soliciting existing or prospective customers if such marketing materials are used without the written consent of the financial institution and in a manner that would lead a reasonable person to believe that the material or solicitation originated from, was endorsed by, or is related to or the responsibility of the financial institution or its affiliates or subsidiaries.

(cc) Unfair rate increases for persons in military service.—Charging an increased premium for reinstating a motor vehicle insurance policy that was canceled or suspended by the insured solely for the reason that he or she was transferred out of this state while serving in the United States Armed Forces or on active duty in the National Guard or United States Armed Forces Reserve. It is also an unfair practice for an insurer to charge an increased premium for a new motor vehicle insurance policy if the applicant for coverage or his or her covered dependents were previously insured with a different insurer and canceled that policy solely for the reason that he or she was transferred out of this state while serving in the United States Armed Forces or on active duty in the National Guard or United States Armed Forces Reserve. For purposes of determining premiums, an insurer shall consider such persons as having maintained continuous coverage.

(dd) Life insurance limitations based on past foreign travel experiences or future foreign travel plans.—

1. An insurer may not refuse life insurance to; refuse to continue the life insurance of; or limit the amount, extent, or kind of life insurance coverage available to an individual based solely on the individual's past lawful foreign travel experiences.

2. An insurer may not refuse life insurance to; refuse to continue the life insurance of; or limit the amount, extent, or kind of life insurance coverage available to an individual based solely on the individual's future lawful travel plans unless the insurer can demonstrate and the Office of Insurance Regulation determines that:

a. Individuals who travel are a separate actuarially supportable class whose risk of loss is different from those individuals who do not travel; and

b. Such risk classification is based upon sound actuarial principles and actual or reasonably anticipated experience that correlates to the risk of travel to a specific destination.

3. The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 necessary to implement this paragraph and may provide for limited exceptions that are based upon national or international emergency conditions that affect the public health, safety, and welfare and that are consistent with public policy.

4. Each market conduct examination of a life insurer conducted pursuant to s. 624.3161 shall include a review of every application under which such insurer refused to issue life insurance; refused to continue life insurance; or limited the amount, extent, or kind of life insurance issued, based upon future lawful travel plans.

5. The administrative fines provided in s. 624.4211(2) and (3) shall be trebled for violations of this paragraph.

6. The Office of Insurance Regulation shall report to the President of the Senate and the Speaker of the House of Representatives by March 1, 2007, and on the same date annually thereafter, on the implementation of this paragraph. The report shall include, but not be limited to, the number of applications under which life insurance was denied, continuance was refused, or coverage was limited based on future travel plans; the number of insurers taking such action; and the reason for taking each such action.

[1](ee) Fraudulent signatures on an application or policy-related document.—Willfully submitting to an insurer on behalf of a consumer an insurance application or policy-related document bearing a false or fraudulent signature.

[1](ff) Unlawful use of designations; misrepresentation of agent qualifications.—

1. A licensee may not, in any sales presentation or solicitation for insurance, use a designation or title in such a way as to falsely imply that the licensee:

a. Possesses special financial knowledge or has obtained specialized financial training; or

b. Is certified or qualified to provide specialized financial advice to senior citizens.

2. A licensee may not use terms such as "financial advisor" in such a way as to falsely imply that the licensee is licensed or qualified to discuss, sell, or recommend financial products other than insurance products.

3. A licensee may not, in any sales presentation or solicitation for insurance, falsely imply that he or she is qualified to discuss, recommend, or sell securities or other investment products in addition to insurance products.

4. A licensee who also holds a designation as a certified financial planner (CFP), chartered life underwriter (CLU), chartered financial consultant (ChFC), life underwriter training council fellow (LUTC), or the appropriate license to sell securities from the Financial Industry Regulatory Authority (FINRA) may inform the customer of those licenses or designations and make recommendations in accordance with those licenses or designations, and in so doing does not violate this paragraph.

(2) ALTERNATIVE RATES OF PAYMENT.—Nothing in this section shall be construed to prohibit an insurer or insurers from negotiating or entering into contracts with licensed health care providers for alternative rates of payment, or from limiting payments under policies pursuant to agreements with insureds, as long as the insurer offers the benefit of such alternative rates to insureds who select designated providers.

(3) INPATIENT FACILITY NETWORK.—This section may not be construed to prohibit a Medicare supplement insurer from granting a premium credit to insureds for using an in-network inpatient facility.

(4) PARTICIPATION IN A WELLNESS OR HEALTH IMPROVEMENT PROGRAM.—

(a) Authorization to offer rewards or incentives for participation.—An insurer issuing a group or individual health benefit plan may offer a voluntary wellness or health improvement program and may encourage or reward participation in the program by authorizing rewards or incentives, including, but not limited to, merchandise, gift cards, debit cards, premium discounts, contributions to a member's health savings account, or modifications to copayment, deductible, or coinsurance amounts. Any advertisement of the program is not subject to the limitations set forth in paragraph (1)(m).

(b) Verification of medical condition by nonparticipants due to medical condition.—An insurer may require a member of a health benefit plan to provide verification, such as an affirming statement from the member's physician, that the member's medical condition makes it unreasonably difficult or inadvisable to participate in the wellness or health improvement program in order for that nonparticipant to receive the reward or incentive.

(c) Disclosure requirement.—A reward or incentive offered under this subsection shall be disclosed in the policy or certificate.

(d) Other incentives.—This subsection does not prohibit insurers from offering other incentives or rewards for adherence to a wellness or health improvement program if otherwise authorized by state or federal law.

626.9641 Policyholders, bill of rights.—

(1) The principles expressed in the following statements shall serve as standards to be followed by the department, commission, and office in exercising their powers and duties, in exercising administrative discretion, in dispensing administrative interpretations of the law, and in adopting rules:

(a) Policyholders shall have the right to competitive pricing practices and marketing methods that enable them to determine the best value among comparable policies.

(b) Policyholders shall have the right to obtain comprehensive coverage.

(c) Policyholders shall have the right to insurance advertising and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy.

(d) Policyholders shall have a right to an insurance company that is financially stable.

(e) Policyholders shall have the right to be serviced by a competent, honest insurance agent or broker.

(f) Policyholders shall have the right to a readable policy.

(g) Policyholders shall have the right to an insurance company that provides an economic delivery of coverage and that tries to prevent losses.

(h) Policyholders shall have the right to a balanced and positive regulation by the department, commission, and office.

(2) This section shall not be construed as creating a civil cause of action by any individual policyholder against any individual insurer.

627.4133 Notice of cancellation, nonrenewal, or renewal premium.—

(1) Except as provided in subsection (2):

(a) An insurer issuing a policy providing coverage for workers' compensation and employer's liability insurance, property, casualty, except mortgage guaranty, surety, or marine insurance, other than motor vehicle insurance subject to s. 627.728, shall give the first-named insured at least 45 days' advance written notice of nonrenewal or of the renewal premium. If the policy is not to be renewed, the written notice shall state the reason or reasons as to why the policy is not to be renewed. This requirement applies only if the insured has furnished all of the necessary information so as to enable the insurer to develop the renewal premium prior to the expiration date of the policy to be renewed.

(b) An insurer issuing a policy providing coverage for property, casualty, except mortgage guaranty, surety, or marine insurance, other than motor vehicle insurance subject to s. 627.728 or s. 627.7281, shall give the first-named insured written notice of cancellation or termination other than nonrenewal at least 45 days prior to the effective date of the cancellation or termination, including in the written notice the reason or reasons for the cancellation or termination, except that:

1. When cancellation is for nonpayment of premium, at least 10 days' written notice of cancellation accompanied by the reason therefor shall be given. As used in this subparagraph and s. 440.42(3), the term "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. If a dishonored check represents the initial premium payment, the contract and all contractual obligations 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; and

2. When such cancellation or termination occurs during the first 90 days during which the insurance is in force and the insurance is canceled or terminated for reasons other than nonpayment of premium, at least 20 days' written notice of cancellation or termination accompanied by the reason therefor shall be given except where there has been a material misstatement or misrepresentation or failure to comply with the underwriting requirements established by the insurer.

After the policy has been in effect for 90 days, no such policy shall be canceled by the insurer except when there has been a material misstatement, a nonpayment of premium, a failure to comply with underwriting requirements established by the insurer within 90 days of the date of effectuation of coverage, or a substantial change in the risk covered by the policy or when the cancellation is for all insureds under such policies for a given class of insureds. This subsection does not apply to individually rated risks having a policy term of less than 90 days.

(c) If an insurer fails to provide the 45-day or 20-day written notice required under this section, the coverage provided to the named insured shall remain in effect until 45 days after the notice is given or until the effective date of replacement coverage obtained by the named insured, whichever occurs first. The premium for the coverage shall remain the same during any such extension period except that, in the event of failure to provide notice of nonrenewal, if the rate filing then in effect would have resulted in a premium reduction, the premium during such extension of coverage shall be calculated based upon the later rate filing.

(2) With respect to any personal lines or commercial residential property insurance policy, including, but not limited to, any homeowner's, mobile home owner's, farmowner's, condominium association, condominium unit owner's, apartment building, or other policy covering a residential structure or its contents:

(a) The insurer shall give the first-named insured at least 45 days' advance written notice of the renewal premium.

(b) The insurer shall give the first-named insured written notice of nonrenewal, cancellation, or termination at least 100 days before the effective date of the nonrenewal, cancellation, or termination. However, the insurer shall give at least 100 days' written notice, or written notice by June 1, whichever is earlier, for any nonrenewal, cancellation, or termination that would be effective between June 1 and November 30. The notice must include the reason or reasons for the nonrenewal, cancellation, or termination, except that:

1. The insurer shall give the first-named insured written notice of nonrenewal, cancellation, or termination at least 120 days prior to the effective date of the nonrenewal, cancellation, or termination for a first-named insured whose residential structure has been insured by that insurer or an affiliated insurer for at least a 5-year period immediately prior to the date of the written notice.

2. If cancellation is for nonpayment of premium, at least 10 days' written notice of cancellation accompanied by the reason therefor must be given. As used in this subparagraph, the term "nonpayment of premium" means failure of the named insured to discharge when due 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. The term 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. If a dishonored check represents the initial premium payment, the contract and all contractual obligations are 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 must be refunded to that party in full.

3. If such cancellation or termination occurs during the first 90 days the insurance is in force and the insurance is canceled or terminated for reasons other than nonpayment of premium, at least 20 days' written notice of cancellation or termination accompanied by the reason therefor must be given unless there has been a material misstatement or misrepresentation or failure to comply with the underwriting requirements established by the insurer.

4. The requirement for providing written notice by June 1 of any nonrenewal that would be effective between June 1 and November 30 does not apply to the following situations, but the insurer remains subject to the requirement to provide such notice at least 100 days before the effective date of nonrenewal:

a. A policy that is nonrenewed due to a revision in the coverage for sinkhole losses and catastrophic ground cover collapse pursuant to s. 627.706.

b. A policy that is nonrenewed by Citizens Property Insurance Corporation, pursuant to s. 627.351(6), for a policy that has been assumed by an authorized insurer offering replacement coverage to the policyholder is exempt from the notice requirements of paragraph (a) and this paragraph. In such cases, the corporation must give the named insured written notice of nonrenewal at least 45 days before the effective date of the nonrenewal.

After the policy has been in effect for 90 days, the policy may not be canceled by the insurer unless there has been a material misstatement, a nonpayment of premium, a failure to comply with underwriting requirements established by the insurer within 90 days after the date of effectuation of coverage, or a substantial change in the risk covered by the policy or if the cancellation is for all insureds under such policies for a given class of insureds. This paragraph does not apply to individually rated risks having a policy term of less than 90 days.

5. Notwithstanding any other provision of law, an insurer may cancel or nonrenew a property insurance policy after at least 45 days' notice if the office finds that the early cancellation of some or all of the insurer's policies is necessary to protect the best interests of the public or policyholders and the office approves the insurer's plan for early cancellation or nonrenewal of some or all of its policies. The office may base such finding upon the financial condition of the insurer, lack of adequate reinsurance coverage for hurricane risk, or other relevant factors. The office may condition its finding on the consent of the insurer to be placed under administrative supervision pursuant to s. 624.81 or to the appointment of a receiver under chapter 631.

6. A policy covering both a home and motor vehicle may be nonrenewed for any reason applicable to either the property or motor vehicle insurance after providing 90 days' notice.

(c) If the insurer fails to provide the notice required by this subsection, other than the 10-day notice, the coverage provided to the named insured shall remain in effect until the effective date of replacement coverage or until the expiration of a period of days after the notice is given equal to the required notice period, whichever occurs first. The premium for the coverage shall remain the same during any such extension period except that, in the

event of failure to provide notice of nonrenewal, if the rate filing then in effect would have resulted in a premium reduction, the premium during such extension shall be calculated based on the later rate filing.

(d)1. Upon a declaration of an emergency pursuant to s. 252.36 and the filing of an order by the Commissioner of Insurance Regulation, an insurer may not cancel or nonrenew a personal residential or commercial residential property insurance policy covering a dwelling or residential property located in this state which has been damaged as a result of a hurricane or wind loss that is the subject of the declaration of emergency for a period of 90 days after the dwelling or residential property has been repaired. A structure is deemed to be repaired when substantially completed and restored to the extent that it is insurable by another authorized insurer that is writing policies in this state.

2. However, an insurer or agent may cancel or nonrenew such a policy prior to the repair of the dwelling or residential property:

a. Upon 10 days' notice for nonpayment of premium; or

b. Upon 45 days' notice:

(I) For a material misstatement or fraud related to the claim;

(II) If the insurer determines that the insured has unreasonably caused a delay in the repair of the dwelling; or

(III) If the insurer has paid policy limits.

3. If the insurer elects to nonrenew a policy covering a property that has been damaged, the insurer shall provide at least 90 days' notice to the insured that the insurer intends to nonrenew the policy 90 days after the dwelling or residential property has been repaired. Nothing in this paragraph shall prevent the insurer from canceling or nonrenewing the policy 90 days after the repairs are complete for the same reasons the insurer would otherwise have canceled or nonrenewed the policy but for the limitations of subparagraph 1. The Financial Services Commission may adopt rules, and the Commissioner of Insurance Regulation may issue orders, necessary to implement this paragraph.

4. This paragraph shall also apply to personal residential and commercial residential policies covering property that was damaged as the result of Tropical Storm Bonnie, Hurricane Charley, Hurricane Frances, Hurricane Ivan, or Hurricane Jeanne.

(e) If any cancellation or nonrenewal of a policy subject to this subsection is to take effect during the duration of a hurricane as defined in s. 627.4025(2)(c), the effective date of such cancellation or nonrenewal is extended until the end of the duration of such hurricane. The insurer may collect premium at the prior rates or the rates then in effect for the period of time for which coverage is extended. This paragraph does not apply to any property with respect to which replacement coverage has been obtained and which is in effect for a claim occurring during the duration of the hurricane.

(3) Claims on property insurance policies that are the result of an act of God may not be used as a cause for cancellation or nonrenewal, unless the insurer can demonstrate, by claims frequency or otherwise, that the insured has failed to take action reasonably necessary as requested by the insurer to prevent recurrence of damage to the insured property.

(4) Notwithstanding s. 440.42(3), if cancellation of a policy providing coverage for workers' compensation and employer's liability insurance is requested in writing by the insured, such cancellation shall be effective on the date requested by the insured or, if no date is specified by the insured, cancellation shall be effective on the date of the written request. The carrier is not required to send notice of cancellation to the insured if the cancellation is requested in writing by the insured. Any retroactive assumption of coverage and liabilities under a policy providing workers' compensation and employer's liability insurance may not exceed 21 days.

(5) An insurer that cancels a property insurance policy on property secured by a mortgage due to the failure of the lender to timely pay the premium when due shall reinstate the policy as required by s. 501.137.

(6) A single claim on a property insurance policy which is the result of water damage may not be used as the sole cause for cancellation or nonrenewal unless the insurer can demonstrate that the insured has failed to take action reasonably requested by the insurer to prevent a future similar occurrence of damage to the insured property.

(7)(a) Effective August 1, 2007, with respect to any residential property insurance policy, every notice of renewal premium must specify:

1. The dollar amounts recouped for assessments by the Florida Hurricane Catastrophe Fund, the Citizens Property Insurance Corporation, and the Florida Insurance Guaranty Association. The actual names of the entities must appear next to the dollar amounts.
2. The dollar amount of any premium increase that is due to an approved rate increase and the total dollar amount that is due to coverage changes.

(b) The Financial Services Commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection.

627.706 Sinkhole insurance; catastrophic ground cover collapse; definitions.—

(1)(a) Every insurer authorized to transact property insurance in this state must provide coverage for a catastrophic ground cover collapse.

(b) The insurer shall make available, for an appropriate additional premium, coverage for sinkhole losses on any structure, including the contents of personal property contained therein, to the extent provided in the form to which the coverage attaches. The insurer may require an inspection of the property before issuance of sinkhole loss coverage. A policy for residential property insurance may include a deductible amount applicable to sinkhole losses equal to 1 percent, 2 percent, 5 percent, or 10 percent of the policy dwelling limits, with appropriate premium discounts offered with each deductible amount.

(c) The insurer may restrict catastrophic ground cover collapse and sinkhole loss coverage to the principal building, as defined in the applicable policy.

(2) As used in ss. 627.706-627.7074, and as used in connection with any policy providing coverage for a catastrophic ground cover collapse or for sinkhole losses, the term:

(a) "Catastrophic ground cover collapse" means geological activity that results in all the following:

1. The abrupt collapse of the ground cover;
2. A depression in the ground cover clearly visible to the naked eye;
3. Structural damage to the covered building, including the foundation; and
4. The insured structure being condemned and ordered to be vacated by the governmental agency authorized by law to issue such an order for that structure.

Contents coverage applies if there is a loss resulting from a catastrophic ground cover collapse. Damage consisting merely of the settling or cracking of a foundation, structure, or building does not constitute a loss resulting from a catastrophic ground cover collapse.

(b) "Neutral evaluation" means the alternative dispute resolution provided in s. 627.7074.

(c) "Neutral evaluator" means a professional engineer or a professional geologist who has completed a course of study in alternative dispute resolution designed or approved by the department for use in the neutral evaluation process and who is determined by the department to be fair and impartial.

(d) "Primary structural member" means a structural element designed to provide support and stability for the vertical or lateral loads of the overall structure.

(e) "Primary structural system" means an assemblage of primary structural members.

(f) "Professional engineer" means a person, as defined in s. 471.005, who has a bachelor's degree or higher in engineering. A professional engineer must also have experience and expertise in the identification of sinkhole activity as well as other potential causes of structural damage.

(g) "Professional geologist" means a person, as defined in s. 492.102, who has a bachelor's degree or higher in geology or related earth science and experience and expertise

in the identification of sinkhole activity as well as other potential geologic causes of structural damage.

(h) "Sinkhole" means a landform created by subsidence of soil, sediment, or rock as underlying strata are dissolved by groundwater. A sinkhole forms by collapse into subterranean voids created by dissolution of limestone or dolostone or by subsidence as these strata are dissolved.

(i) "Sinkhole activity" means settlement or systematic weakening of the earth supporting the covered building only if the settlement or systematic weakening results from contemporaneous movement or raveling of soils, sediments, or rock materials into subterranean voids created by the effect of water on a limestone or similar rock formation.

(j) "Sinkhole loss" means structural damage to the covered building, including the foundation, caused by sinkhole activity. Contents coverage and additional living expenses apply only if there is structural damage to the covered building caused by sinkhole activity.

(k) "Structural damage" means a covered building, regardless of the date of its construction, has experienced the following:

1. Interior floor displacement or deflection in excess of acceptable variances as defined in ACI 117-90 or the Florida Building Code, which results in settlement-related damage to the interior such that the interior building structure or members become unfit for service or represents a safety hazard as defined within the Florida Building Code;

2. Foundation displacement or deflection in excess of acceptable variances as defined in ACI 318-95 or the Florida Building Code, which results in settlement-related damage to the primary structural members or primary structural systems that prevents those members or systems from supporting the loads and forces they were designed to support to the extent that stresses in those primary structural members or primary structural systems exceeds one and one-third the nominal strength allowed under the Florida Building Code for new buildings of similar structure, purpose, or location;

3. Damage that results in listing, leaning, or buckling of the exterior load-bearing walls or other vertical primary structural members to such an extent that a plumb line passing through the center of gravity does not fall inside the middle one-third of the base as defined within the Florida Building Code;

4. Damage that results in the building, or any portion of the building containing primary structural members or primary structural systems, being significantly likely to imminently collapse because of the movement or instability of the ground within the influence zone of the supporting ground within the sheer plane necessary for the purpose of supporting such building as defined within the Florida Building Code; or

5. Damage occurring on or after October 15, 2005, that qualifies as "substantial structural damage" as defined in the Florida Building Code.

(3) Insurers offering policies that exclude coverage for sinkhole losses must inform policyholders in bold type of not less than 14 points as follows: "YOUR POLICY PROVIDES COVERAGE FOR A CATASTROPHIC GROUND COVER COLLAPSE THAT RESULTS IN THE PROPERTY BEING CONDEMNED AND UNINHABITABLE. OTHERWISE, YOUR POLICY DOES NOT PROVIDE COVERAGE FOR SINKHOLE LOSSES. YOU MAY PURCHASE ADDITIONAL COVERAGE FOR SINKHOLE LOSSES FOR AN ADDITIONAL PREMIUM."

(4) An insurer offering sinkhole coverage to policyholders before or after the adoption of s. 30, chapter 2007-1, Laws of Florida, may nonrenew the policies of policyholders maintaining sinkhole coverage at the option of the insurer, and provide an offer of coverage that includes catastrophic ground cover collapse and excludes sinkhole coverage. Insurers acting in accordance with this subsection are subject to the following requirements:

(a) Policyholders must be notified that a nonrenewal is for purposes of removing sinkhole coverage, and that the policyholder is being offered a policy that provides coverage for catastrophic ground cover collapse.

(b) Policyholders must be provided an actuarially reasonable premium credit or discount for the removal of sinkhole coverage and provision of only catastrophic ground cover collapse.

(c) Subject to the provisions of this subsection and the insurer's approved underwriting or insurability guidelines, the insurer shall provide each policyholder with the opportunity to purchase an endorsement to his or her policy providing sinkhole coverage and may require an inspection of the property before issuance of a sinkhole coverage endorsement.

(d) Section 624.4305 does not apply to nonrenewal notices issued pursuant to this subsection.

(5) Any claim, including, but not limited to, initial, supplemental, and reopened claims under an insurance policy that provides sinkhole coverage is barred unless notice of the claim was given to the insurer in accordance with the terms of the policy within 2 years after the policyholder knew or reasonably should have known about the sinkhole loss.

Ch.92-146, Sec. 2, Laws of Florida

From the effective date of this act and through July 1, 1993, no insurer shall nonrenew any policy of property insurance on the basis of filing of claims for partial loss caused by sinkhole damage or clay shrinkage as long as the total as such payments does not exceed the current policy limits of coverage for property damage, and provided the insured has repaired the structure in accordance with the engineering recommendations upon which any payment or policy proceeds was based.

Sec. 4, House Bill 89-B, Special Session B (1983)

Section 627.707, Florida Statutes, 1992 Supplement, is amended to read:

627.707 Minimum standards for investigation of sink hole claims by insurers; nonrenewals.-

(1) Upon receipt of a claim for a sinkhole loss, and insurer must meet the following minimum standards in investigation a claim:

(a)~~(1)~~ Upon receipt of a claim for a sinkhole loss, the insurer must make an inspection of the insured's premises to determine if there has been physical damage to the structure which might be the result of sinkhole activity.

(b)~~(2)~~ If, upon the investigation pursuant to paragraph (a) ~~subsection (1)~~, the insurer discovers damage to a structure which is consistent with sinkhole activity or if the structure is located in close proximity to a structure in which sinkhole damage has been verified, then prior to denying a claim, the insurer must obtain a written certification from an individual qualified to determine the existence of sinkhole activity, stating that the cause of the claim is not sinkhole activity, and that the analysis conducted was of sufficient scope to eliminate sinkhole activity as the cause of damage within a reasonable professional probability. The written certification must also specify the professional discipline and professional licensure or registration under which the analysis was conducted. ~~Effective July 1, 1993, this section is repealed.~~

(c) If the insurer obtains, pursuant to paragraph (b), written certification that the cause of the claim was not sinkhole activity, and if the policyholder has submitted the sinkhole claim without good faith grounds for submitting such claim, the policyholder shall reimburse the insurer for 50 percent of the cost of the analysis under paragraph (b); however, a policyholder is not required to reimburse an insurer more than $2,500 with respect to any claim. A policyholder is required to pay reimbursement under this paragraph only if the insurer prior to ordering the analysis under paragraph (b), informs the policyholder of the policyholder's potential liability for reimbursement and gives the policyholder the opportunity to withdraw the claim.

(2) No insurer shall nonrenew and policy of property insurance on the basis of filing of claims fort partial loss caused by sinkhole damage or clay shrinkage as long as the total of such payments does not exceed the current policy limits of coverage for property damage, and provided the insured has repaired the structure in accordance with the engineering recommendations upon which any payment or policy proceeds was based.

690-170.012
Rulemaking Authority

690-191.072
Rulemaking Authority

641.36 Adoption of rules; penalty for violation.—The commission shall adopt rules necessary to carry ou 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.

641.285 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.

641.285-Insolvency Protection

(5)(a)1. Contracts of insurance or reinsurance on file with the department that will protect subscribers in the event the health maintenance organization is unable to meet its obligations. Each agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. Each agreement and any modification thereto shall be filed with and approved by the department. Each agreement shall remain in full force and in effect until replaced or for at least 90 days following written notification to the department by registered mail of cancellation or termination by either party. The department shall be endorsed on the agreement as an additional insured party.