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

August 7, 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. Request for Approval for Publication of Notice of Repeal to Rule 69O-148.001; Funding of Pre-Need Contracts With Life Insurance or Annuities.

   Rule 69O-148.001 addresses the sale of life and annuity products by agents to fund preneed funeral contracts. The rule currently limits the amount of insurance that may be written to $7,500, which conflicts with section 626.785, Florida Statutes, which permits coverage up to $12,500. The remainder of the rule has essentially the same substantive content as the statute and is unnecessary. As a result, the Office requests this rule be repealed.

   (ATTACHMENT 1) **APPROVAL FOR PUBLICATION**

2. Request for Approval for Publication of Notice of Repeal to Rule 69O-196.008; Failure to Comply

   This rule states that the failure of a premium finance company to comply with the requirements of Part XV, Chapter 627, Florida Statutes, or any of the rules lawfully made pursuant thereto shall cause the premium finance company to be subject to action by the Office under Sections 627.832 and 627.833, Florida Statutes.

   This rule substantially restates the language of Sections 627.832 and 627.833, Florida Statutes and is therefore duplicative. As a result, the Office requests this rule be repealed.

   (ATTACHMENT 2) **APPROVAL FOR PUBLICATION**

3. Request for Approval for Publication of Notice of Repeal to Rule 69O-157.018; Right to Return Policy-Free Look

This rule requires individual long-term care insurers to give policyholders thirty days to examine a policy after its delivery and to return the policy for a full refund of premium if they are not satisfied with the policy for any reason. The rule also requires insurers to provide policyholders with a notice of their right to return the policy within 30 days.

This rule substantially restates the language of Section 627.9407(8), Florida Statutes and is unnecessary. As a result, the Office requests this rule be repealed.

(ATTACHMENT 3) **APPROVAL FOR PUBLICATION**

4. Request for Approval for Publication of Notice of Repeal to Rule 69O-185.005; Advertisement of Mortgage Insurance

   This rule prohibits insurers from insuring mortgages which are offered for sale to the public by advertisements that expressly or impliedly represent that the worth, value or safety of the mortgage investment arises by virtue of the proposed mortgage guaranty insurance rather than by virtue of the value of the underlying security or which stress the fact that the mortgage guarantee insurance is regulated by an agency of the State or Federal Government.

   This rule substantially restates the language of Section 635.071(3), Florida Statutes and is unnecessary. As a result, the Office requests this rule be repealed.

(ATTACHMENT 4) **APPROVAL FOR PUBLICATION**

5. Request for Approval for Publication of Notice of Repeal to Rule 69O-157.105; Refund of Premium

   This rule requires insurers that cancel an insurance policy to refund to the policyholder any unearned premium paid to the insurer.

   This rule substantially restates the language of Section 627.6645(4), Florida Statutes and is unnecessary. As a result, the Office requests this rule be repealed.

(ATTACHMENT 5) **APPROVAL FOR PUBLICATION**

M E M O R A N D U M

DATE: June 28, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for Aug 7, 2012
Request for Approval to Publish Repeal of
Rule 69O-148.001
Funding of Pre-Need Contracts With Life Insurance or Annuities
Assignment # 124727-12

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before Aug 1, 2012 and to the Financial Services Commission on Aug 7, 2012, with a request to approve for publication the proposed rules.

Rule 69O-148.001 addresses the sale of life and annuity products by agents to fund preneed funeral contracts. The rule currently limits the amount of insurance that may be written at $7,500, which conflicts with section 626.785, Florida Statutes that permits coverage up to $12,500, and therefore the rule should be repealed. The remainder of the rule has essentially the same substantive content as the statute and is unnecessary.

Sections 624.308(1), 624.307(1), 626.785, 626.9541(1)(a),(t), 627.410, 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-148.001 Funding of Preneed Contracts With Life Insurance or Annuities.

Rulemaking Authority 624.308(1) FS. Law Implemented 624.307(1), 626.785, 626.9541(1)(a),(t), 627.410 FS. History–New 4-8-97, Formerly 4-148.001, Repeal.

69O-148.001 Funding of Preneed Contracts With Life Insurance or Annuities.

(1) Background and Purpose. The provisions of Section 626.785, Florida Statutes, provide for insurance agents to sell life insurance and annuities on a limited basis to fund preneed services and merchandise. The statute provides that if a funeral establishment contracts with a life insurance agent to sell a preneed contract pursuant to Chapter 497, Florida Statutes, the benefits payable under the insurance contract are limited to the approximate retail price of the funeral service and merchandise. The purpose of this rule is to clarify the statutory limitations to ensure that consumers are protected.

(2) General Limitation. For purposes of Section 626.785, Florida Statutes, and this rule only, and pursuant to Section 624.602, Florida Statutes, the transaction of life insurance shall include the sale of nonvariable type annuities.

(3) Limitation of License. An agent licensed pursuant to Section 626.785(3), Florida Statutes, is limited to selling life insurance and nonvariable type annuity contracts for the purpose of providing funds to pay for funeral services and merchandise selected under the terms of a preneed funeral contract.

(4) "Face Amount" Defined. For purposes of Section 626.785, Florida Statutes, and this rule, the term face amount shall, provided that any subsequent increase in the benefit payable under the life insurance policy or annuity does not exceed the reasonably expected increase in the retail price of the services and merchandise specified in the preneed funeral contract, mean:

(a) The total consideration for an annuity contract; or

(b) As to a life insurance policy with full first day coverage, the death benefit payable at the time the policy is issued; or

(c) As to a life insurance policy which has a limited death benefit in the early years, the death benefit designated at the time the policy is issued which is payable when the limited benefits are inapplicable.

(5) Limitation of Coverage.

(a) Life insurance or nonvariable type annuity contracts may be sold to cover the cost of services and merchandise specified in a preneed funeral contract of an insured or annuitant, provided the face amount of the life insurance policy, or the total consideration paid for such annuity, does not exceed $7,500. Any increase in the death benefit of such life insurance or annuity shall be limited to the reasonably anticipated increase in the retail price of the services and merchandise specified in the preneed funeral contract.

(b) The aggregate amount of insurance proceeds payable under such life insurance or annuity contracts, for the benefit of any one life which may be paid to a preneed certificate holder licensed pursuant to Chapter 497, Florida Statutes, shall not exceed the retail price of the services and merchandise which are provided at time of need. All other proceeds shall be paid to the beneficiary named in such contracts, or, if no beneficiary has been designated, to the estate of the insured or annuitant.

(c) All annuity contracts shall contain an age or event whereby the annuitant shall start receiving annuity benefits. If the maturity date of the annuity contract is age 70 or greater, or upon the death of the annuitant, the annuity contract must permit the contract owner the option to change the maturity date at the owner's option.

(6) Form Filing Notification. Any form filed with the Office pursuant to Section 627.410, Florida Statutes, for use in funding a preneed funeral contract in this State, shall include a notification of the form's intended use for this purpose.

Specific Authority 624.308(1) FS. Law Implemented 624.307(1), 626.785, 626.9541(1)(a),(t), 627.410 FS. History–New 4-8-97, Formerly 4-148.001.

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.

626.785 Qualifications for license.—

(1) The department shall not grant or issue a license as life agent to any individual found by it to be untrustworthy or incompetent, or who does not meet the following qualifications:

(a) Must be a natural person of at least 18 years of age.

(b) Must be a United States citizen or legal alien who possesses work authorization from the United States Bureau of Citizenship and Immigration Services and a bona fide resident of this state.

(c) Must not be an employee of the United States Department of Veterans Affairs or state service office, as referred to in s. 626.788.

(d) Must not be a funeral director or direct disposer, or an employee or representative thereof, or have an office in, or in connection with, a funeral establishment, except that a funeral establishment may contract with a life insurance agent to sell a preneed contract as defined in s. 497.005. Notwithstanding other provisions of this chapter, such insurance agent may sell limited policies of insurance covering the expense of final disposition or burial of an insured in the amount of $12,500, plus an annual percentage increase based on the Annual Consumer Price Index compiled by the United States Department of Labor, beginning with the Annual Consumer Price Index announced by the United States Department of Labor for the year 2003.

(e) Must take and pass any examination for license required under s. 626.221.

(f) Must be qualified as to knowledge, experience, or instruction in the business of insurance and meet the requirements relative thereto provided in s. 626.7851.

(2) An individual who is a bona fide resident of this state shall be deemed to meet the residence requirement of paragraph (1)(b), notwithstanding the existence at the time of application for license of a license in his or her name on the records of another state as a resident licensee of such other state, if the applicant furnishes a letter of clearance satisfactory to the department that the resident licenses have been canceled or changed to a nonresident basis and that he or she is in good standing.

(3) Notwithstanding any other provisions of this chapter, a funeral director, a direct disposer, or an employee of a funeral establishment that holds a certificate of authority pursuant to s. 497.452 may obtain an agent's license to sell only policies of life insurance covering the expense of a prearrangement for funeral services or merchandise so as to provide funds at the time the services and merchandise are needed. The face amount of insurance covered by any such policy shall not exceed $12,500, plus an annual percentage increase based on the Annual Consumer Price Index compiled by the United States Department of Labor, beginning with the Annual Consumer Price Index announced by the United States Department of Labor for 2003.

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.

(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.

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 28, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for Aug 7, 2012
Request for Approval to Publish Repeal of
Rule 69O-196.008
Failure to Comply
Assignment # 126034-12

The Office of Insurance Regulation requests that this proposed rule repeal be presented to the Cabinet aides on or before Aug 1, 2012 and to the Financial Services Commission on Aug 7, 2012, with a request to approve for publication the proposed rule repeal.

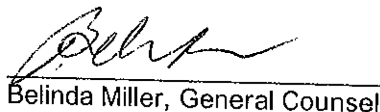
This rule states that the failure of a premium finance company to comply with the requirements of Part XV, Chapter 627, Florida Statutes, or any of the rules lawfully made pursuant thereto shall cause the premium finance company to be subject to action by the Office under Sections 627.832 and 627.833, Florida Statutes.

This rule substantially restates the language of Sections 627.832 and 627.833, Florida Statutes and is unnecessary. As a result, this rule should be repealed.

Sections 624.308, 624.307(1), 627.832, 627.833, F.S., provide rulemaking authority and laws implemented for this rule.

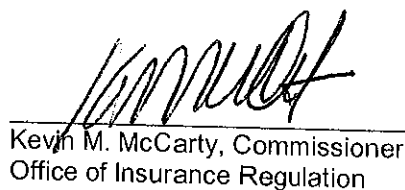
Jason Nelson is the attorney handling this rule repeal. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:



Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:



Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-196.008 Failure to Comply.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 627.832, 627.833 FS. History–New 10-20-73, Repromulgated 12-24-74, Formerly 4-18.08, 4-18.008, Amended 7-27-95, Formerly 4-196.008, Repealed.

69O-196.008 Failure to Comply.

Failure by a premium finance company to comply with any of the requirements of Part XV, Chapter 627, F.S., or any of the rules lawfully made pursuant thereto shall cause the premium finance company to be subject to action by the Office under Sections 627.832 and 627.833, F.S.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 627.832, 627.833 FS. History–New 10-20-73, Repromulgated 12-24-74, Formerly 4-18.08, 4-18.008, Amended 7-27-95, Formerly 4-196.008.

624.308 Rules.—

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

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

624.307 General powers; duties.—

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

627.832 Grounds for refusal, suspension, or revocation of license.—

(1) The office may deny, suspend, revoke, or refuse to renew any license, if it finds:

(a) That the licensee has failed to pay the annual license fee or any sum of money lawfully demanded under authority of any other section of this part or has failed to comply with any order of the office.

(b) That the licensee has violated any provision of this part or any rule of the commission.

(c) That any fact or condition exists which, if it had existed at the time of the original application, clearly would have warranted a refusal to issue the license.

(d) Material misstatement, misrepresentation, or fraud in obtaining the license or permit, or in attempting to obtain the license or permit.

(e) That the license or permit is being willfully used, or is to be used, to circumvent any of the requirements or prohibitions of this code.

(f) Willful misrepresentation of any premium finance contract or willful deception with regard to any such contract, accomplished either in person or by any form of dissemination of information.

(g) A demonstrated lack of fitness or trustworthiness.

(h) Fraudulent or dishonest practices in the conduct of business.

(i) Misappropriation, conversion, or unlawful withholding of moneys belonging to insurers, insureds, or beneficiaries or to others and received in the conduct of business.

(j) That the licensee has been found guilty of, or has pleaded guilty to, a felony in this state or any other state.

(2) A licensee may surrender a license by delivering to the office written notice that she or he thereby surrenders such license, but such surrender shall not affect such licensee's civil or criminal liability for acts committed prior to such surrender.

(3) No revocation, suspension, or surrender of a license shall impair or affect the obligation of any insured under any lawful premium finance agreement previously acquired or held by the licensee.

(4) Every license issued hereunder shall remain in force and effect until it has been surrendered, revoked, or suspended or expires in accordance with the provisions of this part; but the office may reinstate a suspended license or issue a new license to a licensee whose license has been revoked, if no fact or condition then exists which clearly would have warranted office refusal originally to issue such license under this part.

627.833 Administrative fine and probation in lieu of suspension, revocation, or refusal to renew license.– The office may, in its discretion in lieu of a suspension, revocation, or refusal to renew or continue any license, impose on the licensee an administrative penalty or place such licensee on probation pursuant to s 626.681 and 626.691.

M E M O R A N D U M

DATE: June 28, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

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Assignment # 126039-12

The Office of Insurance Regulation requests that this proposed rule repeal be presented to the Cabinet aides on or before Aug 1, 2012 and to the Financial Services Commission on Aug 7, 2012, with a request to approve for publication the proposed rule repeal.

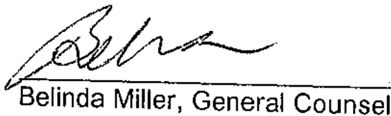
This rule requires individual long-term care insurers to give policyholders thirty days to examine a policy after its delivery and to return the policy for a full refund of premium if they are not satisfied with the policy for any reason. The rule also requires insurers to provide insureds with a notice of their right to return the policy within 30 days.

This rule substantially restates the language of Section 627.9407(8), Florida Statutes and is unnecessary. As a result, this rule should be repealed.

Sections 624.308(1), 627.9407(1), 624.307(1), F.S., provide rulemaking authority and laws implemented for this rule.

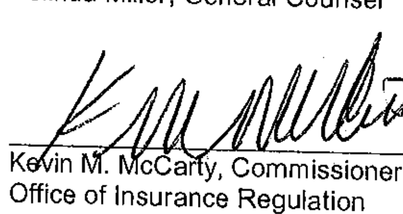
JN ✓ Jason Nelson is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:



Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:



Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-157.018 Right to Return Policy - Free Look.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9407(1), (7) FS. History–New 5-17-89, Formerly 4-81.018, 4-157.018, Repealed.

69O-157.018 Right to Return Policy - Free Look.

(1) The insured shall have thirty days after delivery of an individual long-term care policy to examine it and return it to the agent or the entity for a full refund of premium if, after examination of the policy, they are not satisfied for any reason.

(2) A notice on individual contracts of the requirements of subsection (1), above, shall be prominently printed on the face of the policy or attached thereto.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9407(1), (7) FS. History–New 5-17-89, Formerly 4-81.018, 4-157.018.

69O-157.018
Rulemaking Authority

624.308 Rules.—

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

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

627.9407 Disclosure, advertising, and performance standards for long-term care insurance.—

(1) STANDARDS.—The commission shall adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures of the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, disclosure of tax consequences, benefit triggers, prohibition against post-claims underwriting, reporting requirements, standards for marketing, and definitions of terms.

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: June 28, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for Aug 7, 2012
Request for Approval to Publish Repeal of
Rule 69O-185.005
Advertisement of Mortgage Insurance
Assignment # 126040-12

The Office of Insurance Regulation requests that this proposed rule repeal be presented to the Cabinet aides on or before Aug 1, 2012 and to the Financial Services Commission on Aug 7, 2012, with a request to approve for publication the proposed rule repeal.

This rule prohibits insurers from insuring mortgages which are offered for sale to the public by advertisements that expressly or impliedly represent that the worth, value or safety of the mortgage investment arises by virtue of the proposed mortgage guaranty insurance rather than by virtue of the value of the underlying security or which stress the fact that the mortgage guarantee insurance is regulated by an agency of the State or Federal Government.

This rule substantially restates the language of Section 635.071(3), Florida Statutes and is unnecessary. As a result, this rule should be repealed.

Sections 635.081, 635.071, F.S., provide rulemaking authority and laws implemented for this rule.

JN 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-185.005 Advertisement of Mortgage Insurance.

Specific Authority 635.081 FS. Law Implemented 635.071 FS. History–Repromulgated 12-24-74, Formerly 4-2.09, 4-2.009, 4-185.005, Repealed.

69O-185.005 Advertisement of Mortgage Insurance.

No company shall insure mortgages which are being offered for sale to the public by advertisement, either in newspapers, brochures, direct mail or like media, where such advertisement expressly or impliedly represents or stresses that the worth, value, or safety of such mortgage investment arises by virtue of proposed mortgage guaranty insurance rather than by virtue of the safety inherent in the value of the underlying security as it relates to the face value of the mortgage debt or which stress the fact that same is regulated by an agency of the State or Federal Government.

Specific Authority 635.081 FS. Law Implemented 635.071 FS. History–Repromulgated 12-24-74, Formerly 4-2.09, 4-2.009, 4-185.005.

69O-185.005
Rulemaking Authority

635.081 Administration and enforcement.—

The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of t chapter and shall have the same powers of administration and enforcement of the provisions of this chapter as it has with respect to casualty or surety insurers in general under the Florida Insurance Code

635.071 Filings, approval of forms; rate filings.—

(1) No policy form or related form may be issued or used in this state unless it has been filed with and approved by the office as provided by laws applicable to casualty or surety insurance.

(2) Each insurer shall file with the office for informational purposes the rate to be charged and the premium to be paid by the policyholder, including all modifications of rates and premiums.

(3) An insurer may not insure mortgages that are offered for sale to the public by advertisement, whether in newspapers, brochures, direct mailings, or similar media, if the advertisement expressly or impliedly represents or stresses that the worth, value, or safety of the mortgage investment arises by virtue of the proposed mortgage guaranty insurance rather than by virtue of the safety inherent in the value of the underlying security as it relates to the face value of the mortgage debt, or if the advertisement stresses the fact that the mortgage guaranty insurance is regulated by an agency of the state or Federal Government.

M E M O R A N D U M

DATE: June 28, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill DT
Jason Nelson

SUBJECT: Cabinet Agenda for Aug 7, 2012
Request for Approval to Publish Repeal of
Rule 69O-157.105
Refund of Premium
Assignment # 126042-12

The Office of Insurance Regulation requests that this proposed rule repeal be presented to the Cabinet aides on or before Aug 1 2012 and to the Financial Services Commission on Aug 7, 2012, with a request to approve for publication the proposed rule repeal.

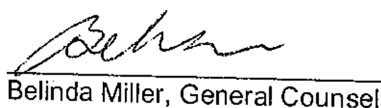
This rule requires insurers that cancel an insurance policy to refund to the policyholder any unearned premium paid to the insurer.

This rule substantially restates the language of Section 627.6645(4), Florida Statutes and is unnecessary. As a result, this rule should be repealed.

Sections 624.308(1), 627.9407(1), 627.9407(6), 624.307(1), 627.6043, 627.6645, 627.9407, 627.9408, F.S., provide rulemaking authority and laws implemented for this rule.

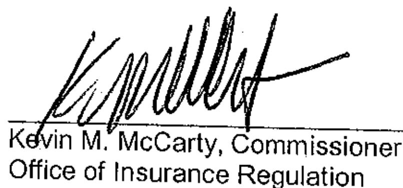
JN Jason Nelson is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:



Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:



Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-157.105 Refund of Premium.

Specific Authority 624.308(1), 627.9407(1), (6), 627.9408 FS. Law Implemented 624.307(1), 627.6043, 627.6645, 627.9407 FS. History–New 1-13-03, Formerly 4-157.105,Repealed.

69O-157.105 Refund of Premium.

In the event of cancellation, the insurer shall return the unearned portion of any premium paid.

Specific Authority 624.308(1), 627.9407(1), (6), 627.9408 FS. Law Implemented 624.307(1), 627.6043, 627.6645, 627.9407 FS. History–New 1-13-03, Formerly 4-157.105.

690-157.105
Rulemaking Authority

624.308 Rules.—

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

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

627.9407 Disclosure, advertising, and performance standards for long-term care insurance.—

(1) STANDARDS.—The commission shall adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures of the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, disclosure of tax consequences, benefit triggers, prohibition against post-claims underwriting, reporting requirements, standards for marketing, and definitions of terms.

(6) LOSS RATIO AND RESERVE STANDARDS.—The commission shall adopt rules establishing loss ratio and reserve standards for long-term care insurance policies. The rules must contain a specific reference to long-term care insurance policies. Such loss ratio and reserve standards shall be established at levels at which benefits are reasonable in relation to premiums and that provide for adequate reserving of the long-term care insurance risk.

624.307 General powers; duties.—

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

627.6043 Notification of cancellation, nonrenewal, or change in rates.—

(1) Any insurer delivering or issuing an individual health insurance policy subject to this part shall give the policyholder at least 45 days' advance written notice of cancellation, nonrenewal, or a change in rates. Such notice shall be mailed to the policyholder's last address as shown by the records of the insurer. However, if cancellation is for nonpayment of premium, at least 10 days' written notice accompanied by the reason therefor shall be given. Written notice of cancellation for nonpayment of premium shall not be required for health insurance policies under which premiums are payable monthly or more frequently and regularly collected by a licensed agent.

(2) In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(3) If the insurer fails to provide the 45 days' notice required by this section, the coverage shall remain in effect at the existing premium until 45 days after the notice is given or until the effective date of replacement coverage obtained by the insured, whichever occurs first.

627.6645 Notification of cancellation, expiration, nonrenewal, or change in rates.—

(1) Every insurer delivering or issuing for delivery a group health insurance policy under the provisions of this part shall give the policyholder at least 45 days' advance notice of cancellation, expiration, nonrenewal, or a change in rates. Such notice shall be mailed to the policyholder's last address as shown by the records of the insurer. However, if

cancellation is for nonpayment of premium, only the requirements of subsection (5) apply. Upon receipt of such notice, the policyholder shall forward, as soon as practicable, the notice of expiration, cancellation, or nonrenewal to each certificateholder covered under the policy.

(2) If an insurer bills any certificateholder directly at his or her home address for collection of any premiums due, the notice required by subsection (1) shall be provided by the insurer directly to each such certificateholder covered under the policy.

(3) If the insurer fails to provide the 45 days' notice required by this section, the coverage shall remain in effect at the existing rates until 45 days after the notice is given or until the effective date of replacement coverage obtained by the insured, whichever occurs first.

(4) In the event of cancellation, the insurer must return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(5) If cancellation is due to nonpayment of premium, the insurer may not retroactively cancel the policy to a date prior to the date that notice of cancellation was provided to the policyholder unless the insurer mails notice of cancellation to the policyholder prior to 45 days after the date the premium was due. Such notice must be mailed to the policyholder's last address as shown by the records of the insurer and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due.

627.9407 Disclosure, advertising, and performance standards for long-term care insurance.—

(1) STANDARDS.—The commission shall adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures of the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, disclosure of tax consequences, benefit triggers, prohibition against post-claims underwriting, reporting requirements, standards for marketing, and definitions of terms.

(2) ADVERTISING.—The commission shall adopt rules setting forth standards for advertising, marketing, and sale of long-term care policies in order to protect applicants from unfair or deceptive sales or enrollment practices. An insurer shall file with the office any long-term care insurance advertising material intended for use in this state at least 30 days before the date of use of the advertisement in this state. Within 30 days after the date of receipt of the advertising material, the office shall review the material and shall disapprove any advertisement if, in the opinion of the office, such advertisement violates any of the provisions of this part or of part IX of chapter 626 or any rule of the commission. The office may disapprove an advertisement at any time and enter an immediate order requiring that the use of the advertisement be discontinued if it determines that the advertisement violates any of the provisions of this part or of part IX of chapter 626 or any rule of the commission.

(3) RESTRICTIONS.—A long-term care insurance policy may not:

(a) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder; however, the office may authorize nonrenewal for an insurer on a statewide basis on terms and conditions determined to be necessary by the office to protect the interests of the insureds, if the insurer demonstrates that renewal will jeopardize the insurer's solvency or

that substantial and unexpected loss experience cannot reasonably be mitigated or remedied.

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same insurer or any affiliated insurer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(c) Restrict its coverage to care only in a nursing home licensed pursuant to part II of chapter 400 or provide significantly more coverage for such care than coverage for lower levels of care. The commission shall adopt rules defining what constitutes significantly more coverage in nursing homes licensed pursuant to part II of chapter 400 than for lower levels of care.

(d) Contain an elimination period in excess of 180 days. As used in this paragraph, the term "elimination period" means the number of days at the beginning of a period of confinement for which no benefits are payable.

(4) PREEXISTING CONDITION.—

(a) A long-term care insurance policy or certificate, other than a policy or certificate issued to a group referred to in s. 627.9405(1)(a), may not use a definition of "preexisting condition" which is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months preceding the effective date of coverage of an insured person.

(b) A long-term care insurance policy or certificate, other than a policy or certificate issued to a group referred to in s. 627.9405(1)(a), may not exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(c) The office may extend the limitation periods set forth in paragraphs (a) and (b) as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of "preexisting condition" specified in paragraph (a) does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) expires. A long-term care insurance policy or certificate may not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (b).

(5) PRIOR INSTITUTIONALIZATION.—

(a) A long-term care insurance policy may not be delivered or issued for delivery in this state if the policy:

1. Conditions eligibility for any benefits on a prior hospitalization requirement;
2. Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or
3. Conditions eligibility for any benefits other than waiver of premium, postconfinement, postacute care, or recuperative benefits on a prior institutionalization requirement.

(b)1. A long-term care insurance policy containing postconfinement, postacute care, or recuperative benefits must clearly specify, in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits," the applicable limitations or conditions, including any required number of days of confinement.

2. A long-term care insurance policy or rider that conditions eligibility for noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days.

(6) LOSS RATIO AND RESERVE STANDARDS.—The commission shall adopt rules establishing loss ratio and reserve standards for long-term care insurance policies. The rules must contain a specific reference to long-term care insurance policies. Such loss ratio and reserve standards shall be established at levels at which benefits are reasonable in relation to premiums and that provide for adequate reserving of the long-term care insurance risk.

(7) RATE STRUCTURE.—

(a) A long-term care insurance policy may not be issued if the premiums to be charged are calculated to increase based solely on the age of the insured.

(b) Any long-term care insurance policy or certificate issued or renewed, at the option of the policyholder or certificateholder, shall make available to the insured the contingent benefit upon lapse as provided in the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in the second quarter of the year 2000.

(c) Any premium increase for existing insureds shall not result in a premium charged to the insureds that would exceed the premium charged on a newly issued insurance policy, except to reflect benefit differences. If the insurer is not currently issuing new coverage, the new business rate shall be as published by the office at the rate representing the new business rate of insurers representing 80 percent of the carriers currently issuing policies with similar coverage as determined by the prior calendar year earned premium.

(d) Compliance with the pooling provisions of s. 627.410(6)(e)3. shall be determined by pooling the experience of all affiliated insurers.

(8) RIGHT TO RETURN; FREE LOOK.—An individual long-term care insurance policyholder has the right to return the policy within 30 days after its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. An individual long-term care insurance policy must have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder has the right to return the policy within 30 days after its delivery and to have the premium refunded directly to the policyholder if, after examination of the policy, the policyholder is not satisfied for any reason.

(9) STAMPED AS "LONG-TERM CARE INSURANCE POLICY"; NOTICE TO BUYER.—A long-term care insurance policy must contain a stamp prominently displayed on the first page of the policy that the policy has been approved as a "Long-Term Care Insurance Policy" meeting the requirements of Florida law. In addition, the following statement shall be prominently displayed on the first page of the policy: "Notice to Buyer: This policy may not cover all of the costs associated with long-term care which may be incurred by the buyer during the period of coverage. The buyer is advised to periodically review this policy in relation to the changes in the cost of long-term care."

(10) OUTLINE OF COVERAGE.—An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) If the policy is not expected to cover 100 percent of the cost of services for which coverage is provided, a statement clearly describing any such limitation;

(d) A statement of the renewal provisions, including any reservation in the policy of a right to change premiums;

(e) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(6) LOSS RATIO AND RESERVE STANDARDS.—The commission shall adopt rules establishing loss ratio and reserve standards for long-term care insurance policies. The rules must contain a specific reference to long-term care insurance policies. Such loss ratio and reserve standards shall be established at levels at which benefits are reasonable in relation to premiums and that provide for adequate reserving of the long-term care insurance risk.

(7) RATE STRUCTURE.—

(a) A long-term care insurance policy may not be issued if the premiums to be charged are calculated to increase based solely on the age of the insured.

(b) Any long-term care insurance policy or certificate issued or renewed, at the option of the policyholder or certificateholder, shall make available to the insured the contingent benefit upon lapse as provided in the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in the second quarter of the year 2000.

(c) Any premium increase for existing insureds shall not result in a premium charged to the insureds that would exceed the premium charged on a newly issued insurance policy, except to reflect benefit differences. If the insurer is not currently issuing new coverage, the new business rate shall be as published by the office at the rate representing the new business rate of insurers representing 80 percent of the carriers currently issuing policies with similar coverage as determined by the prior calendar year earned premium.

(d) Compliance with the pooling provisions of s. 627.410(6)(e)3. shall be determined by pooling the experience of all affiliated insurers.

(8) RIGHT TO RETURN; FREE LOOK.—An individual long-term care insurance policyholder has the right to return the policy within 30 days after its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. An individual long-term care insurance policy must have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder has the right to return the policy within 30 days after its delivery and to have the premium refunded directly to the policyholder if, after examination of the policy, the policyholder is not satisfied for any reason.

(9) STAMPED AS "LONG-TERM CARE INSURANCE POLICY"; NOTICE TO BUYER.—A long-term care insurance policy must contain a stamp prominently displayed on the first page of the policy that the policy has been approved as a "Long-Term Care Insurance Policy" meeting the requirements of Florida law. In addition, the following statement shall be prominently displayed on the first page of the policy: "Notice to Buyer: This policy may not cover all of the costs associated with long-term care which may be incurred by the buyer during the period of coverage. The buyer is advised to periodically review this policy in relation to the changes in the cost of long-term care."

(10) OUTLINE OF COVERAGE.—An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) If the policy is not expected to cover 100 percent of the cost of services for which coverage is provided, a statement clearly describing any such limitation;

(d) A statement of the renewal provisions, including any reservation in the policy of a right to change premiums;

(e) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(f) A statement that the policy has been approved as a long-term care insurance policy meeting the requirements of Florida law.

(11) CERTIFICATE.—A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy; and

(c) A statement that the description of principal benefits is a summary of the policy and that the group master policy should be consulted to determine governing contractual provisions.

(12) DISCLOSURE.—A qualified long-term care insurance policy must include a disclosure statement within the policy and within the outline of coverage that the policy is intended to be a qualified long-term contract. A long-term care insurance policy that is not intended to be a qualified long-term care insurance contract must include a disclosure statement within the policy and within the outline of coverage that the policy is not intended to be a qualified long-term care insurance contract. The disclosure shall be prominently displayed and shall read as follows: "This long-term care insurance policy is not intended to be a qualified long-term care insurance contract. You need to be aware that benefits received under this policy may create unintended, adverse income tax consequences to you. You may want to consult with a knowledgeable individual about such potential income tax consequences."

(13) ADDITIONAL DISCLOSURE.—A limited benefit policy qualified under s. 7702B of the Internal Revenue Code must include a disclosure statement within the policy and within the outline of coverage that the policy is intended to be a qualified limited benefit insurance contract. A limited benefit policy that is not intended to be a qualified limited benefit insurance contract must include a disclosure statement within the policy and within the outline of coverage that the policy is not intended to be a qualified limited benefit insurance contract. The disclosure must be prominently displayed and must read as follows: "This limited benefit insurance policy is not intended to be a qualified limited benefit insurance contract. You need to be aware that benefits received under this policy may create unintended, adverse income tax consequences to you. You may want to consult with a knowledgeable individual about such potential income tax consequences."

627.9408 Rules.—

(1) The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to administer this part.

(2) The commission may adopt by rule the provisions of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in the second quarter of the year 2000 which are not in conflict with the Florida Insurance Code.