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

December 9, 2014

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

Contact: **Karen Kees**
(850-413-2474)

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

ITEM	SUBJECT	RECOMMENDATION

1. Minutes of the Financial Services Commission for April 22, 2014.

   http://www.myflorida.com/myflorida/cabinet/agenda14/0422/transcript.pdf

(ATTACHMENT 1) **FOR APPROVAL**

2. Request for Approval for Publication of Proposed Amendment to Rule 69O-162.102,.103,.104,.106,.108; Annuity Contracts

   The change adopts annuity mortality tables for use in financial reporting of annuity reserves as set forth in Section 625.121 Florida Statutes. The added new mortality table, recently adopted by the NAIC, is based upon recent annuitant mortality of insurers. Adoption will create uniformity among states following NAIC model regulation.

(ATTACHMENT 2) **APPROVAL FOR PUBLICATION**

3. Request for Approval for Publication of Proposed Amendment to Rule 69O-144.005,.007; Credit for Reinsurance From Eligible Reinsurers

   These rules are being amended in order to conform to the National Association of Insurance Commissioners (NAIC) model laws for accreditation purposes and to provide consistency among regulatory jurisdictions as to the manner in which reinsurers are granted the status of "certified reinsurer" (currently termed "eligible reinsurer" in the rule) and the manner in which Florida domestic insurance companies can apply credit for reinsurance from these entities. The amendments pertain to a requirement that ceding insurers notify the Office in the event that reinsurance recoverables or reinsurance ceded exceeds a certain amount; the filing requirements for certified reinsurers; the factors to be considered in the evaluation and rating of certified reinsurers; the method by which a jurisdiction is determined to be qualified;

the circumstances under which the Commissioner may suspend, revoke, or otherwise modify a certified reinsurer's certification; and the effect of a rating downgrade, rating upgrade, or revocation of the certification of a certified reinsurer.

(ATTACHMENT 3) **APPROVAL FOR PUBLICATION**

4. Request for Approval for Publication of Proposed Amendment to Rule 69O-137.001; Annual and Quarterly Reporting Requirements

   These rules are being amended to adopt the 2015 NAIC Quarterly Statement Manuals, the 2014 NAIC Annual Statement Instructions Manuals, and the 2014 and 2015 NAIC Accounting Practices and Procedures Manuals. The current rule adopted the 2013 NAIC Quarterly Statement Manuals, the 2012 NAIC Annual Statement Instructions Manuals, and the 2012 and 2013 NAIC Accounting Practices and Procedures Manuals. The rule is also being updated to reflect the current process for filing the annual and quarterly statements as well as to specify that annual and quarterly statements are to be filed electronically and not in any other format.

(ATTACHMENT 4) **APPROVAL FOR PUBLICATION**

5. Request for Approval for Publication of Proposed Amendment to Rule 69O-138.001:NAIC Financial Condition Examiners Handbook Adopted

   These rules are being amended to adopt the 2014 and 2015 NAIC Financial Condition Examiners Handbooks. The current rule adopted the 2013 and 2012 versions of these handbooks.

(ATTACHMENT 5) **APPROVAL FOR PUBLICATION**

6. Request for Approval for Final Adoption of Proposed Amendment to Rule 69O-148.001; Funding of Preneed Contracts With Life Insurance Annuities

   The Rule addresses requirements for insurance policies which fund preneed contracts. Currently, the rule caps the maximum face amount at $7,500 and the statute caps the maximum face amount at $12,500. The rule as amended will cross reference to the statute which provides for the limit on the maximum face amount.

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

7. Request for Approval for Final Adoption of Proposed Repeal of Rule Chapter 69O-123; Civil Remedy and Rule Chapter 69O-228; Continuing Education

   Rule Chapter 69O-123, Florida Administrative Code, should be repealed because DFS handles these matters and already has a similar rule.

Rule Chapter 69O-228 was promulgated to establish requirements and standards for continuing education courses and records for persons: (1) licensed to solicit or sell insurance or act as limited surety or bail bond agents, (2) licensed to adjust workers' compensation claims in this state and (3) authorized to offer or teach related coursework in this state.

Section 626.2816, Florida Statutes, specifically requires the Department of Financial Services to adopt rules relating to continuing education of this type. Towards this end, the Department of Financial Services has promulgated Rule Chapter 69B-228. The Office does not have sufficient statutory authority to enforce the rules contained in Rule Chapter 69O-228 and as a result this rule chapter should be repealed.

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

STATE OF FLORIDA

IN RE: MEETING OF THE GOVERNOR AND CABINET

_____/

CABINET MEMBERS:	GOVERNOR RICK SCOTT ATTORNEY GENERAL PAM BONDI CHIEF FINANCIAL OFFICER JEFF ATWATER COMMISSIONER OF AGRICULTURE ADAM PUTNAM
DATE:	TUESDAY, APRIL 22, 2014
LOCATION:	CABINET MEETING ROOM LOWER LEVEL, THE CAPITOL TALLAHASSEE, FLORIDA
REPORTED BY:	NANCY S. METZKE, RPR, FPR COURT REPORTER

C & N REPORTERS
POST OFFICE BOX 3093
TALLAHASSEE, FLORIDA 32315-3093
(850) 697-8314 / FAX (850) 697-8715
nancy@metzke.com
candnreporters.com

OFFICE OF INSURANCE REGULATION

GOVERNOR SCOTT: Now I'd to recognize Commissioner Kevin McCarty to present his agenda.

Good afternoon, Kevin.

COMMISSIONER McCARTY: Good afternoon, Governor, Members of the Commission.

Our first agenda item is request approval of the minutes of the December 10th, 2013, meeting of the Financial Services Commission.

GOVERNOR SCOTT: Is there a motion to approve?

CFO ATWATER: So moved.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Moved and seconded, show the minutes approved without objection.

COMMISSIONER McCARTY: With regards to Item Number 2, the Office respectfully requests withdrawal of this agenda item.

GOVERNOR SCOTT: Is there a motion to approve the withdrawal?

CFO ATWATER: So move.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Any comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER McCARTY: Yes, Item Number 3 is request for approval for publication proposed amendments to rules concerning our premium contracts for life insurance annuities. This amendment to the rule removes the dollar cap amount that is currently in our rule which is in conflict with the statute, so it simply removes that and allows the statute to govern without respect to any limitation that's in the rule.

Recommend adoption.

GOVERNOR SCOTT: Is there a motion to approve?

ATTORNEY GENERAL BONDI: So move.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Any comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER McCARTY: Item 4 is a request for publication of two rules seeking to repeal. The Office seeks to repeal rules contained in Rule Chapter 69-123 related to civil remedies, and

Section 624 of Florida Statutes gives the Department of Financial Services the authority to enforce this statute and not the Office of Insurance Regulation.

The Office also seeks the repeal of the rule contained in Chapter 690-228 regarding continuing education. Again, this is under the purview of the Department of Financial Services.

We request that these rules be repealed. There will be no harm to consumers. The consumers will continue to be protected under the supervision of the Department of Financial Services.

GOVERNOR SCOTT: Is there a motion to approve?

CFO ATWATER: So moved.

GOVERNOR SCOTT: Is there a second?

COMMISSIONER PUTNAM: Second.

GOVERNOR SCOTT: Any comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER McCARTY: Thank you, Governor. Thank you, members.

GOVERNOR SCOTT: This concludes our Cabinet Meeting. Our next meeting will be Tuesday, May 13th at 9 a.m. We are adjourned.

M E M O R A N D U M

DATE: November 3, 2014

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

THROUGH: Belinda Miller, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for December 9, 2014
Request for Approval to Publish Amendments to
Rule 69O-162.102, .103, .104,.106, .108
Annuity Contracts
Assignment # 130494-13

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before December 3, 2014, and to the Financial Services Commission on December 9, 2014, with a request to approve for publication the proposed rules.

The change adopts annuity mortality tables for use in financial reporting of annuity reserves as set forth in Section 625.121 Florida Statutes. The added new mortality table, recently adopted by the NAIC, is based upon recent annuitant mortality of insurers. Adoption will create uniformity among states following NAIC model regulation.

Sections 624.308, 625.121(5)(j), 624.307(1), 625.121, F.S., provide rulemaking authority and laws implemented for these rules.

Stephen Fredrickson 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

CHAPTER 69O-162

ANNUITY CONTRACTS

69O-162.102 Purpose.

The purpose of this rule is to recognize the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts: the Annuity 2000 Mortality Table, ~~and~~ the 1994 Group Annuity Reserving (1994 GAR) Table, and the 2012 IAR Mortality Table.

Rulemaking Authority 624.308, 625.121(5)(i) FS. Law Implemented 624.307(1), 625.121 FS. History–New 12-23-98, Formerly 4-162.102 Amended_____.

69O-162.103 Definitions.

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

(1) "1994 GAR Table" – means that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force.

(2) "Annuity 2000 Mortality Table" means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research.

(3) "Period table" means a table of mortality rates applicable to a given calendar year (the Period).

(4) "Generational mortality table" means a mortality table containing a set of mortality rates that decrease for a given age from one year to the next based on a combination of a Period table and a projection scale containing rates of mortality improvement.

(5) "2012 IAR Table" means that Generational mortality table developed by the Society of Actuaries Committee on Life Insurance Research and containing rates, q_x^{2012+n}, derived from a combination of the 2012 IAM Period Table and Projection Scale G2, using the methodology stated in 69O-162.106(2).

(6) "2012 Individual Annuity Mortality Life (2012 IAM Period) Table" means the Period table containing loaded mortality rates for calendar year 2012. This table contains rates, q_x^{2012}, developed by the Society of Actuaries Committee on Life Insurance Research .

(7) "Projection Scale G2 (Scale G2)" is a table of annual rates, $G2_x$, of mortality improvement by age for projecting future mortality rates beyond calendar year 2012. This table was developed by the Society of Actuaries Committee on Life Insurance Research.

Rulemaking Authority 624.308, 625.121(5)(i) FS. Law Implemented 624.307(1), 625.121 FS. History–New 12-23-98, Formerly 4-162.103, Amended_____.

69O-162.104 Individual Annuity or Pure Endowment Contracts.

(1) The Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after July 1, 1998 and on or before December 31, 20143.

~~(2) The 1983 Table "a" without projection is to be used for determining the minimum standard of valuation for an individual annuity or pure endowment contract issued on or after July 1, 1998, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:~~

~~(a) Settlements of various forms of claims pertaining to court settlements or out-of-court settlements for tort actions;~~

~~(b) Settlements involving similar actions such as workers compensation claims; or~~

~~(c) Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.~~

(2) The 2012 IAR Table shall be used for determining the minimum standard of valuation for any

individual annuity or pure endowment contract issued on or after January 1, 2015, for valuation dates on or after March 31, 2015.

(3) The 1983 Table "a" without projection is to be used for determining the minimum standard of valuation for an individual annuity or pure endowment contract issued on or after July 1, 1998, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

(a) Settlements of various forms of claims pertaining to court settlements or out of court settlements for tort actions;

(b) Settlements involving similar actions such as workers compensation claims; or

(c) Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

Rulemaking Authority 624.308, 625.121(5)(i) FS. Law Implemented 624.307(1), 625.121 FS. History–New 12-23-98, Formerly 4-162.104, Amended_____.

69O-162.106 Application of 1994 GAR Table and the 2012 IAR Mortality Table.

(1) In using the 1994 GAR Table, the mortality rate for a person age x in year (1994 + n) is calculated as follows:

$q_x^{1994+n} = q_x^{1994}(1 - AA_x)^n$

where q_x^{1994}s and AA_xs are as specified in the 1994 GAR Table.

(2) In using the 2012 IAR Mortality Table, the mortality rate for a person age x in year (2012 + n) is calculated as follows:

$q_x^{2012+n} = q_x^{2012}(1 - G2_x)^n$

(a) The resulting q_x^{2012+n} shall be rounded to three decimal places per 1,000, e.g., 0.741 deaths per 1,000. Also, the rounding shall occur according to the formula above, starting at the 2012 period table rate.

(b) For example, for a male age 30, $q_x^{2012} = 0.741$.

1. $q_x^{2013} = 0.741 * (1 - 0.010) \wedge 1 = 0.73359$, which is rounded to 0.734.

2. $q_x^{2014} = 0.741 * (1 - 0.010) \wedge 2 = 0.7262541$, which is rounded to 0.726.

(c) A method leading to incorrect rounding would be to calculate q_x^{2014} as $q_x^{2013} * (1 - 0.010)$, or $0.734 * 0.99 = 0.727$. It is incorrect to use the already rounded q_x^{2013} to calculate q_x^{2014}.

Rulemaking Authority 624.308, 625.121(5)(i) FS. Law Implemented 624.307(1), 625.121 FS. History–New 12-23-98, Formerly 4-162.106, Amended _____.

69O-162.108 Tables.

(1) The following tables are hereby adopted and incorporated by reference:

(a) The Annuity 2000 Mortality Table;

(b) The 1994 GAR Table;

(c) The 1983 Table "a";

(d) The 2012 IAR Mortality Table and The Projection Scale G2 (Scale G2),

(2) The tables in subsection (1) are available from the Office of Insurance Regulation, ~~Bureau of~~ Life and Health Financial Oversight ~~Insurer Solvency~~, 200 East Gaines Street, Tallahassee, Florida 32399-0327.

Rulemaking Authority 624.308, 625.121(5)(i) FS. Law Implemented 624.307(1), 625.121 FS. History–New 12-23-98, Formerly 4-162.108, Amended _____.

690-162
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.

625.121 Standard Valuation Law; life insurance.—
(1) SHORT TITLE.—This section shall be known as the "Standard Valuation Law."
(2) ANNUAL VALUATION.—The office shall annually value, or cause to be valued, the reserve liabilities, hereinafter called "reserves," for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer doing business in this state, and may certify the amount of any such reserves, specifying the mortality table or tables, rate or rates of interest, and methods, net-level premium method or others, used in the calculation of such reserves. In the case of an alien insurer, such valuation shall be limited to its insurance transactions in the United States. In calculating such reserves, the office may use group methods and approximate averages for fractions of a year or otherwise. It may accept in its discretion the insurer's calculation of such reserves. In lieu of the valuation of the reserves herein required of any foreign or alien insurer, it may accept any valuation made or caused to be made by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard herein provided and if the official of such state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the office when such certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction. When any such valuation is made by the office, it may use the actuary of the office or employ an actuary for the purpose; and the reasonable compensation of the actuary, at a rate approved by the office, and reimbursement of travel expenses pursuant to s. 624.320 upon demand by the office, supported by an itemized statement of such compensation and expenses, shall be paid by the insurer. When a domestic insurer furnishes the office with a valuation of its outstanding policies as computed by its own actuary or by an actuary deemed satisfactory for the purpose by the office, the valuation shall be verified by the actuary of the office without cost to the insurer.
(3) ACTUARIAL OPINION OF RESERVES.—
(a)1. Each life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commission by rule are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commission by rule shall define the specifics of this opinion and add any other items determined to be necessary to its scope.
2. The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1992.
3. The opinion shall apply to all business in force, including individual and group health insurance plans, in the form and substance acceptable to the office as specified by rule of the commission.
4. The commission may adopt rules providing the standards of the actuarial opinion consistent with standards adopted by the Actuarial Standards Board on December 31, 2002, and subsequent revisions thereto, provided that the standards remain substantially consistent.
5. In the case of an opinion required to be submitted by a foreign or alien company, the office may accept the opinion filed by that company with the insurance supervisory official

of another state if the office determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.
6. For the purposes of this subsection, "qualified actuary" means a member in good standing of the American Academy of Actuaries who also meets the requirements specified by rule of the commission.
7. Disciplinary action by the office against the company or the qualified actuary shall be in accordance with the insurance code and related rules adopted by the commission.
8. A memorandum in the form and substance specified by rule shall be prepared to support each actuarial opinion.
9. If the insurance company fails to provide a supporting memorandum at the request of the office within a period specified by rule of the commission, or if the office determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by rule of the commission, the office may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the office.
10. Except as otherwise provided in this paragraph, any memorandum or other material in support of the opinion is confidential and exempt from the provisions of s. 119.07(1); however, the memorandum or other material may be released by the office with the written consent of the company, or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the office for preserving the confidentiality of the memorandum or other material. If any portion of the confidential memorandum is cited by the company in its marketing or is cited before any governmental agency other than a state insurance department or is released by the company to the news media, no portion of the memorandum is confidential.
(b) In addition to the opinion required by subparagraph (a)1., the office may, pursuant to commission rule, require an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commission by rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including, but not limited to, the benefits under, and expenses associated with, the policies and contracts.
(c) The commission may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this subsection.
(4) MINIMUM STANDARD FOR VALUATION OF POLICIES AND CONTRACTS ISSUED BEFORE OPERATIVE DATE OF STANDARD NONFORFEITURE LAW.—The minimum standard for the valuation of all such policies and contracts issued prior to the operative date of s. 627.476 (Standard Nonforfeiture Law) shall be any basis satisfactory to the office. Any basis satisfactory to the former Department of Insurance on the effective date of this code shall be deemed to meet such minimum standards.
(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.
(6) MINIMUM STANDARD OF VALUATION.—
(a) The interest rates used in determining the minimum standard for the valuation of:
1. All life insurance policies issued in a particular calendar year on or after the operative date of s. 627.476(9);
2. All individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982;
3. All annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts; and
4. The net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts,

shall be the calendar year statutory valuation interest rates for the year-of-issue purchase or increase as defined in this subsection.

(b) The calendar year statutory valuation interest rates I shall be determined as follows, and the results rounded to the nearest 0.25 percent:
1. For life insurance:

I = 0.03 + W(R1-0.03) + (W/2)(R2-0.09).

For purposes of this subparagraph, "R1" is the lesser of R and .09; "R2" is the greater of R and .09; "R" is the reference interest rate defined in this subsection; and "W" is the weighting factor defined in this subsection.

2. For single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

I = 0.03 + W(R-0.03).

For purposes of this subparagraph, "R" is the reference interest rate defined in this subsection, and "W" is the weighting factor defined in this subsection.

3. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue-year basis, except as stated in subparagraph 2., the formula for life insurance stated in subparagraph 1. shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years, and the formula for single-premium immediate annuities stated in subparagraph 2. shall apply to annuities and guaranteed interest contracts with guarantee durations of 10 years or less.
4. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single-premium immediate annuities stated in subparagraph 2. shall apply.
5. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change-in-fund basis, the formula for single-premium immediate annuities stated in subparagraph 2. shall apply.

However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than 0.5 percent, the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980, the reference interest rate defined for 1979 being used, and shall be determined for each subsequent calendar year regardless of when s. 627.476(9) becomes operative.

(c) The weighting factors referred to in the formulas stated in paragraph (b) are given in the following tables:
1. Weighting factors for life insurance:

Guarantee Duration Weighting

(Years) Factors

10 or less:.....0.50

More than 10, but not more than 20:.....0.45

More than 20:.....0.35

For life insurance, the "guarantee duration" is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy.

2. Weighting factor for single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: 0.80.
3. Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subparagraph 2., shall be as specified in sub-subparagraphs a., b., and c., according to the rules and definitions in sub-subparagraphs d., e., and f. and in paragraph (f):
a. For annuities and guaranteed interest contracts valued on an issue-year basis:

Guarantee Duration Weighting Factor

(Years) for Plan Type

5 or less:.....A–0.80

B–0.60

C–0.50

More than 5, but not more than 10:.....A–0.75

B–0.60

C–0.50

More than 10, but not more than 20:.....A–0.65

B–0.50

C–0.45

More than 20:.....A–0.45

B–0.35

C–0.35

b. For annuities and guaranteed interest contracts valued on a change-in-fund basis, the factors shown in sub-subparagraph a. increased by: 0.15 for Plan Type A; 0.25 for Plan Type B; 0.05 for Plan Type C.
c. For annuities and guaranteed interest contracts valued on an issue-year basis, other than those with no cash settlement options, which do not guarantee interest on considerations received more than 1 year after issue or purchase and for annuities and guaranteed interest contracts valued on a change-in-fund basis which do not guarantee interest rates on considerations received more than 12 months beyond the valuation date,

the factors shown in sub-subparagraph a. or derived in sub-subparagraph b. increased by: 0.05 for Plan Type A; 0.05 for Plan Type B; 0.05 for Plan Type C.
d. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the "guarantee duration" is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.
e. "Plan type," as used in the tables above, is defined as follows:
(I) Plan Type A: At any time, the policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; the policyholder may withdraw funds only without such adjustment but in installments over 5 years or more; the policyholder may withdraw funds only as an immediate life annuity; or no withdrawal is permitted.
(II) Plan Type B: Before expiration of the interest rate guarantee, the policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; the policyholder may withdraw funds only without such adjustment but in installments over 5 years or more; or no withdrawal is permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than 5 years.
(III) Plan Type C: The policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than 5 years either without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer or subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.
f. An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue-year basis or on a change-in-fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue-year basis.
(d) The "reference interest rate" referred to in paragraph (b) is defined as follows:
1. For all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of the interest rate index.
2. For single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of the interest rate index.
3. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in subparagraph 2., with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the interest rate index.
4. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in subparagraph 2., with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the interest rate index.
5. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the interest rate index.
6. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change-in-fund basis, except as stated in

subparagraph 2., the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of the interest rate index.
(e) The interest rate index shall be the Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., as long as this index is calculated by using substantially the same methodology as used by it on January 1, 1981. If Moody's corporate bond yield average ceases to be calculated in this manner, the interest rate index shall be the index approved by rule promulgated by the commission. The methodology used in determining the index approved by rule shall be substantially the same as the methodology employed on January 1, 1981, for determining Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc.
(f) As used in this subsection, an "issue-year basis" of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of purchase of the annuity or guaranteed interest contract; and the "change-in-fund" basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.
(7) COMMISSIONERS' RESERVE VALUATION METHOD.—
(a)1. Except as otherwise provided in this subsection and subsections (11) and (14), reserves according to the commissioners' reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then-present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then-present value of such benefits provided for by the policy and the excess of sub-subparagraph a. over sub-subparagraph b. as follows:
a. A net-level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net-level annual premium shall not exceed the net-level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age 1 year higher than the age at issue of such policy.
b. A net-1-year-term premium for such benefits provided for in the first policy year.
2. For any life insurance policy which is issued on or after January 1, 1985, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess, and which provides an endowment benefit, a cash surrender value, or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners' reserve valuation method as of any policy anniversary occurring on or before the assumed ending date, defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium, shall, except as otherwise provided in subsection (11), be the greater of the reserve as of such policy anniversary calculated as described in subparagraph 1. and the reserve as of such policy anniversary calculated as described in subparagraph 1. but with:
a. The value defined in subparagraph 1. being reduced by 15 percent of the amount of such excess first year premium;
b. All present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date;

c. The policy being assumed to mature on such date as an endowment; and
d. The cash surrender value provided on such date being considered as an endowment benefit.

In making the above comparison, the mortality and interest bases stated in subsections (5) and (6) shall be used.

(b) Reserves according to the commissioners' reserve valuation method for:
1. Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;
2. Group annuity and pure endowment contracts, purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under s. 408 of the Internal Revenue Code, as now or hereafter amended;
3. Disability and accidental death benefits in all policies and contracts; and
4. All other benefits, except life insurance and endowment benefits in life insurance policies, and benefits provided by all other annuity and pure endowment contracts,

shall be calculated by a method which is consistent with and yields results consistent with the principles of paragraph (a).

(c) This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under s. 408 of the Internal Revenue Code, as now or hereafter amended. Reserves according to the commissioners' annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate or rates specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.
(8) MINIMUM AGGREGATE RESERVES.—
(a) In no event shall an insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after the operative date of s. 627.476, be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (7), (11), and (12) and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.
(b) In no event may the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the qualified actuary to be necessary to render the opinion required by subsection (3).
(9) OPTIONAL RESERVE BASIS.—
(a) Reserves for all policies and contracts issued prior to the operative date of s. 627.476 may be calculated, at the option of the insurer, according to any standards which produce

greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to such date.
(b) For any category of policies, contracts, or benefits specified in subsections (5) and (6), issued on or after the operative date of s. 627.476 (the Standard Nonforfeiture Law for Life Insurance), reserves may be calculated, at the option of the insurer, according to any standard or standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided; but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for therein.
(10) LOWER VALUATIONS.—An insurer which at any time had adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided may, with the approval of the office, adopt any lower standard of valuation, but not lower than the minimum herein provided; however, for the purposes of this subsection, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required by subsection (3) shall not be deemed to be the adoption of a higher standard of valuation.
(11) DEFICIENCY RESERVE.—If in any contract year the gross premium charged by any life insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, there shall be maintained on such policy or contract a deficiency reserve in addition to the reserve defined by subsections (7) and (12). For each such policy or contract, the deficiency reserve shall be the present value, according to the minimum valuation standards of mortality and rate of interest, of the differences between all such valuation net premiums and the corresponding premiums charged for such policy or contract during the remainder of the premium-paying period. For any category of policies, contracts, or benefits specified in subsections (5) and (6), issued on or after the operative date of s. 627.476 (the Standard Nonforfeiture Law for Life Insurance), the aggregate deficiency reserves may be reduced by the amount, if any, by which the aggregate reserves actually calculated in accordance with subsection (9) exceed the minimum aggregate reserves prescribed by subsection (8). The minimum valuation standards of mortality and rate of interest referred to in this subsection are those standards stated in subsections (5) and (6). However, for any life insurance policy which is issued on or after January 1, 1985, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess, and which provides an endowment benefit, a cash surrender value, or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection shall be applied as if the method actually used in calculating the reserve for such policy were the method described in subsection (7), the provisions of subparagraph (7)(a)2. being ignored. The amount of the deficiency reserve, if any, at each policy anniversary of such a policy shall be the excess, if any, of the amount determined by the foregoing provisions of this subsection plus the reserve calculated by the method described in subsection (7), the provisions of subparagraph (7)(a)2. being ignored, over the reserve actually calculated by the method described in subsection (7), the provisions of subparagraph (7)(a)2. being taken into account.
(12) ALTERNATE METHOD FOR DETERMINING RESERVES IN CERTAIN CASES.—In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in subsection (7), the reserves which are held under any such plan shall:
(a) Be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(b) Be computed by a method which is consistent with the principles of this section, as determined by rules promulgated by the commission.
(13) CREDIT LIFE AND DISABILITY POLICIES.—
(a) For policies issued prior to January 1, 2004:
1. The minimum reserve for single-premium credit disability insurance, monthly premium credit life insurance, and monthly premium credit disability insurance shall be the unearned gross premium.
2. As to single-premium credit life insurance policies, the insurer shall establish and maintain reserves that are not less than the value, at the valuation date, of the risk for the unexpired portion of the period for which the premium has been paid as computed on the basis of the commissioners' 1980 Standard Ordinary Mortality Table and 3.5 percent interest. At the discretion of the office, the insurer may make a reasonable assumption as to the ages at which net premiums are to be determined. In lieu of the foregoing basis, reserves based upon unearned gross premiums may be used at the option of the insurer.
(b) For policies issued on or after January 1, 2004:
1. The minimum reserve for single-premium credit disability insurance shall be either:
a. The unearned gross premium, or
b. Based upon a morbidity table that is adopted by the National Association of Insurance Commissioners and is specified in a rule the commission adopts pursuant to subsection (14).
2. The minimum reserve for monthly premium credit disability insurance shall be the unearned gross premium.
3. The minimum reserve for monthly premium credit life insurance shall be the unearned gross premium.
4. As to single-premium credit life insurance policies, the insurer shall establish and maintain reserves that are not less than the value, at the valuation date, of the risk for the unexpired portion of the period for which the premium has been paid as computed on the basis of the commissioners' 1980 Standard Ordinary Mortality Table or any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule adopted by the commission for use in determining the minimum standard of valuation for such policies; and an interest rate determined in accordance with subsection (6). At the discretion of the office, the insurer may make a reasonable assumption as to the ages at which net premiums are to be determined. In lieu of the foregoing basis, reserves based upon unearned gross premiums may be used at the option of the insurer.
(14) MINIMUM STANDARDS FOR HEALTH PLANS.—The commission shall adopt a rule containing the minimum standards applicable to the valuation of health plans in accordance with sound actuarial principles.

M E M O R A N D U M

DATE: November 12, 2014

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

THROUGH: Belinda Miller, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for December 9, 2014
Request for Approval to Publish Amendments to
Rule 69O-144.005,.007 Credit for Reinsurance; Credit for Reinsurance From Eligible Reinsurers
Assignment # 142116-13

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before December 3, 2014 and to the Financial Services Commission on December 9, 2014, with a request to approve for publication the proposed rules.

These rules are being amended in order to conform to the National Association of Insurance Commissioners (NAIC) model laws for accreditation purposes and to provide consistency among regulatory jurisdictions as to the manner in which reinsurers are granted the status of "certified reinsurer" (currently termed "eligible reinsurer" in the rule) and the manner in which Florida domestic insurance companies can apply credit for reinsurance from these entities. The amendments pertain to a requirement that ceding insurers notify the Office in the event that reinsurance recoverables or reinsurance ceded exceeds a certain amount; the filing requirements for certified reinsurers; the factors to be considered in the evaluation and rating of certified reinsurers; the method by which a jurisdiction is determined to be qualified; the circumstances under which the Commissioner may suspend, revoke, or otherwise modify a certified reinsurer's certification; and the effect of a rating downgrade, rating upgrade, or revocation of the certification of a certified reinsurer.

Sections 624.308, 624.610(14), 624.307(1), 624.610, F.S., provide rulemaking authority and laws implemented for these rules.

Stephen Fredrickson and Alyssa Lathrop are the attorneys 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-144.005 Credit for Reinsurance.

(1) No change.

(2) Credit for reinsurance by a domestic insurer shall be allowed when the reinsurance is ceded to an assuming insurer which is accredited as a reinsurer in this state pursuant to Section 624.610(3)(b), F.S.,~~Florida Statutes~~ and Rule 69O-144.002, F.A.C., as of any date on which statutory financial statement credit for reinsurance is claimed. An accredited reinsurer pursuant to Section 624.610(3)(b), F.S.~~Florida Statutes~~:

(a)1. No change.

2. Form OIR-C1-1464 is available on the Office's web site located at https://www.floir.com and shall be filed electronically via the Office's Online Company Admissions system, "iApply," located at http://www.floir.com/iportal; ~~from, and shall be submitted to the following: for life and health insurers, Life and Health Financial Oversight, 200 East Gaines Street, Tallahassee, Florida 32399-0327; for property and casualty insurers, Property and Casualty Financial Oversight, 200 East Gaines Street, Tallahassee, Florida 32399-0329;~~

(b) No change.

(c) Files annually and quarterly with the Office via the Office's Regulatory Electronic Filing System, "REFS," located at http://www.floir.com/iportal, a copy of its annual and quarterly statements prepared in accordance with the National Associatoin of Insurance Commissioners manuals adopted in Rule 69O-137.001, F.A.C., ~~filed on the National Association of Insurance Commissioners convention blanks, which are hereby adopted and incorporated by reference,~~ with the insurance department of its state of domicile or, in the case of a U.S. branch of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recent audited financial statement and maintains a

surplus as regards policyholders in accordance with Section 624.610(3)(b)1.d., F.S., and whose approval has been granted by the Office. If quarterly statements are not required by the state of domicile, quarterly statements shall only be required upon written request of the Office. ~~The following National Association of Insurance Commissioners blanks are hereby adopted and incorporated by reference:~~

~~1. NAIC Annual Statement Blank Life/Accident/Health 2005,~~

~~2. NAIC Quarterly Statement Blank Life/Accident/Health 2005,~~

~~3. NAIC Annual Statement Blank Health 2005,~~

~~4. NAIC Quarterly Statement Blank Health 2005,~~

~~5. NAIC Annual Statement Blank Property and Casualty 2005, and~~

~~6. NAIC Quarterly Statement Blank Property and Casualty 2005.~~

(3) No change.

(4) Credit for Reinsurance – Reinsurers Maintaining Trust Funds.

(a)1. Pursuant to Section 624.610(3)(c)1., F.S.~~Florida Statutes~~, the Office shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of any date on which statutory financial statement credit for reinsurance is claimed, and thereafter for so long as credit for reinsurance is claimed, maintains a trust fund in an amount prescribed below in a qualified financial institution as defined in Section 624.610(5)(b), F.S.~~Florida Statutes~~, for the payment of the valid claims of its U.S. domiciled ceding insurers, their assigns and successors in interest.

2. No change.

(b) The following requirements apply to the following categories of assuming insurer:

1.a. No change.

b. The assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except

as provided in paragraph c. of this subsection.

c. At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of U.S. ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than thirty percent (30%) of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.

2. No change.

(c)-(d) No change.

(e) Assets deposited in the trust and the trusteed surplus of a single assuming insurer shall consist of assets of a quality and limitation substantially similar to that required in Part II of Chapter 625, F.S.~~Florida Statutes~~, and shall be valued according to their fair market value.

(f) Assets deposited in the trust and the trusteed surplus of a group including incorporated and individual unincorporated underwriters established to meet the requirements of Section 624.610(3)(c)3.b., F.S.~~Florida Statutes~~, shall be of the type and subject to limitations of the following:

1. Assets deposited in the trusts established pursuant to Section 624.610(3)(c)3.b., F.S.~~Florida~~

~~Statutes~~, and this section shall be valued according to their fair market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. financial institution as defined in Section 624.610(5)(a), F.S.~~Florida Statutes~~, clean irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified U.S. financial institution, as defined in Section 624.610(5)(a), F.S.~~Florida Statutes~~, and investments of the type specified in this subsection.

2.-5. No change.

(5) Trust agreements qualified under Section 624.610(4), F.S.~~Florida Statutes.~~

(a) No change.

(b) Required conditions:

1. The trust agreement shall be entered into between the beneficiary, the grantor and a trustee, which shall be a qualified U.S.~~United States~~ financial institution as defined in Section 624.610(5)(b), F.S.~~Florida Statutes.~~

2.-10. No change.

11. Notwithstanding other provisions of this rule, when a trust agreement is established to meet the requirements of Section 624.610(4), F.S.~~Florida Statutes~~, in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

a.-b. No change.

c. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain

unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S.~~United States~~ financial institution apart from its general assets, in trust for such uses and purposes specified in a. and b. above as may remain executory after the withdrawal and for any period after the termination date.

12. Notwithstanding other provisions of this rule, when a trust agreement is established to meet the requirements of Section 624.610(4), F.S.~~Florida Statutes~~, in conjunction with a reinsurance agreement covering life, annuities, or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

a.-c. No change.

13.-14. No change.

(c) No change.

(d) A reinsurance agreement may contain provisions that stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash in U.S.~~United States~~ dollars, certificates of deposit issued by a U.S.~~United States~~ bank and payable in U.S.~~United States~~ dollars, and investments permitted by Part II of Chapter 625, F.S.~~of the Florida Insurance Code~~ or any combination of the above, provided investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent (5%) of total investments. The reinsurance agreement may further specify the types of investments to be deposited. Where a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and

health, then the trust agreement may contain the provisions required by this paragraph in lieu of including such provisions in the reinsurance agreement.

(6) Letters of credit qualified under Section 624.610(4)(c), F.S.~~Florida Statutes.~~

(a)1. The letter of credit shall be clean, irrevocable, unconditional, and issued or confirmed by a qualified U.S.~~United States~~ financial institution.

2. As used in this subsection (6), a qualified U.S.~~United States~~ financial institution is one which meets the definition set forth in Section 626.7492(2)(j), F.S.~~Florida Statutes.~~

3.-6. No change.

(b) No change.

(c) The letter of credit shall contain a statement to the effect that the obligation of the qualified U.S.~~United States~~ financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

(d) No change.

(e)1. No change.

2. All drafts drawn on the letter of credit shall be presentable at an office in the United States of a qualified U.S.~~United States~~ financial institution.

(f) The letter of credit shall be issued or confirmed by a qualified U.S.~~United States~~ financial institution authorized to issue letters of credit, pursuant to Section 624.610(5)(a), F.S.~~Florida Statutes.~~

(g) No change.

(7) Credit shall be allowed foreign and alien insurers when the reinsurance is ceded to an assuming insurer which is domiciled or licensed in, or, in the case of a U.S. branch of an alien assuming insurer is entered through, a state which employs standards regarding credit for

reinsurance substantially similar to those applicable under these rules, and the assuming insurer and the reinsurance agreement meets the requirements established by this rule and Section 624.610, F.S.~~Florida Statutes.~~

(8) A domestic ceding insurer shall notify the Office within thirty (30) days after reinsurance recoverables from any single assuming insurer, or group of assuming insurers, exceeds fifty percent (50%) of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(9) A domestic ceding insurer shall notify the Office within thirty (30) days after ceding to any single assuming insurer, or group of assuming insurers, more than twenty percent (20%) of the domestic ceding insurer's gross written premium in the prior calendar year, or after it is determined that the reinsurance ceded to any single assuming insurer, or group of assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

Specific Authority 624.308, 624.610(14), FS. Law Implemented 624.307(1), 624.610 FS. History–New 1-30-91, Formerly 4-108.005, Amended 12-25-97, 10-13-02, Formerly 4-144-005, Amended 9-14-06, _____.

69O-144.007 Credit for Reinsurance from Certified ~~Eligible~~ Reinsurers.

(1) Purpose. ~~Paragraph (3)(e) of~~ Section 624.610(3)(e), F.S., gives the Office ~~Commissioner~~ the option to allow credit for reinsurance without full collateral for transactions involving assuming insurers not meeting the requirements of Section~~s~~ 624.610(3)(a), (b), (c), or (d) ~~(d)~~, F.S. These rules implement that subsection ~~paragraph~~. This rule does not apply to assuming insurers ~~reinsurers~~ that meet the requirements of Section~~s~~ 624.610(3)(a), (b), (c), or (d) ~~(d)~~, F.S. This rule is not an attempt to assert extra-territorial jurisdiction. Insurers that write in states other than Florida will need to comply with the laws of those states. ~~This rule applies only to property and casualty insurance; it does not apply to life and health.~~

(2) Definitions. As used in this rule the following terms have the following meanings:

(a) "Ceding insurer" means a domestic insurer, as defined by ~~paragraph (1) of~~ Section 624.06(1), F.S.

(b) "Certified ~~Eligible~~ reinsurer" means an assuming insurer that may ~~which does~~ not meet the requirements of ~~paragraphs (3)(a), (3)(b), or (3)(c) of~~ Section 624.610(3)(a), (b), (c), or (d), F.S., and that ~~which~~ has been determined by the Office ~~commissioner~~ by order to have met the requirements set forth in subsections (7) and (8) of this rule.

(c) "Qualified ~~Eligible~~ jurisdiction" means a jurisdiction which has met the requirements set forth in subsection (9~~8~~) of this rule.

(3) Credit for reinsurance under this section shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. ~~With respect to reinsurance contracts entered into or renewed on or after the effective date of this rule, a ceding insurer may elect to take credit, as an asset or deduction from reserves, for reinsurance ceded to a certified an eligible reinsurer,~~ provided that the certified ~~eligible~~ reinsurer holds surplus in excess of

$250 ~~100~~ million and maintains~~, on a stand-alone basis separate from its parent or any affiliated entities,~~ a secure financial strength rating from at least two of the rating agencies indicated in paragraphs (a) through (e)~~(d)~~ of this subsection. Due consideration shall be given to the group rating where appropriate. The credit is subject to the limitations set forth in this rule. As provided in Section 624.610(e), F.S., the ~~The~~ rating agencies are:

(a) Standard and Poor's;

(b) Moody's Investors Service;

(c) Fitch Ratings;

(d) A.M. Best Company; and ~~or~~

(e) Demotech.

(4) The collateral required to allow one hundred percent (100%) credit shall be no less than the percentage specified for the lowest rating as indicated below:

Rating	Collateral Required	Best	S&P	Moody's	Fitch	Demotech
Secure – 1	0%	A++	AAA	Aaa	AAA	A"
Secure – 2	10%	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-	A'
Secure – 3	20%	A~~,A-~~	A+, A~~,A-~~	A1, A2~~,A3~~	A+, A~~,A-~~	A
Secure – 4	50%	A-	A-	A3	A-	n/a
Secure – 5	75%	B++, B+	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-	n/a
Vulnerable – 6	100%	B, B-, C++, C+, C, C-, D, E, F	BB+, BB, BB-, B+, B, B, CCC, CC, C, D, R~~,NR~~	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB-, B+, B, B-, CCC+, ~~CCC,~~ CC, CCC-, ~~C,~~ DD	n/a

For reinsurance ceded by Florida domestic property insurers for short-tailed lines as defined below, any collateral required to be posted may be subject to a one-year deferral from the date of the first instance of a liability reserve entry as a result of a catastrophic loss from a named Hurricane. For

these purposes, a short-tailed line of business is defined as any one of the following lines of business as reported on the NAIC annual financial statement:

Line 1 Fire

Line 2 Allied Lines

Line 3 Farmowners multiple peril

Line 4 Homeowners multiple peril

Line 5 Commercial multiple peril

Line 9 Inland marine

Line 12 Earthquake

Line 21 Auto physical damage

(5) Nothing in this rule shall be construed to deny the ceding insurer the ability to take credit for reinsurance for the remainder of its liabilities with a certified ~~an eligible~~ reinsurer so long as those amounts are secured with acceptable collateral pursuant to Section 624.610(4), F.S.

(6) In addition to the trust fund required under ~~paragraph (3)(c) of~~ Section 624.610(3)(c), F.S., the Office ~~commissioner~~ shall permit an assuming insurer that maintains a trust fund in a qualified U.S. ~~United States~~ financial institution, as that term is defined in ~~paragraph (5)(b) of~~ Section 624.610(5)(b), F.S., for the payment of the valid claims of its U.S. ~~United States~~ cedent insurers and their assigns and successors in interest to also maintain in a qualified U.S. ~~United States~~ financial institution a trust fund constituting a trusteed amount at least equal to the collateral required in accordance with subsection (4) of this rule to secure the liabilities attributable to U.S. ~~United States~~ cedent insurers under reinsurance policies (contracts) entered into or renewed by such assuming insurer on or after the effective date of this rule or such other date as may be established in other

states for cedent insurers domiciled in such states, but only when maintenance of such a trust fund serves to protect the interests of the public and the interests of insurer solvency.

(7) A ceding insurer may not take credit pursuant to this rule unless:

(a) The assuming insurer ~~reinsurer~~ has been determined, by order of the Office ~~commissioner~~, to be a certified ~~an eligible~~ reinsurer, pursuant to subsection (8) of this rule;

(b) The ceding insurer maintains satisfactory evidence that the certified ~~eligible~~ reinsurer meets the standards of solvency, including standards for capital adequacy, established by its domestic regulator; and

(c) All reinsurance contracts between the ceding insurer and the certified ~~eligible~~ reinsurer ~~must~~ provide:

1. For an insolvency clause in conformance with Section 624.610(8), F.S.;

2. For a service of process clause in conformance with Section 624.610(3)(f)1. and 2., ~~;~~ F.S.; and

3. For a submission to jurisdiction clause in conformance with Section 624.610(3)(f)1. and 2., F.S.

(8) Status as certified ~~eligible~~ reinsurer:

(a) Application for a determination as a certified ~~an eligible~~ reinsurer under this rule shall be made by cover letter from the insurer requesting a finding of certification ~~eligibility~~ as a reinsurer pursuant to this rule and shall be filed electronically via the Office's Online Company Admissions system, "iApply," located at http://www.floir.com/iportal. The cover letter shall be accompanied with the following:

1. Audited financial statements prepared on a U.S. GAAP basis for the last three (3) years as filed with the insurer's domiciliary jurisdiction. With permission of the Office, an insurer may provide audited International Financial Reporting Standards (IFRS) basis statements so long as they include

an audited reconciliation of equity and net income on a U.S. GAAP basis, or, with the permission of the Office, audited IFRS statements with a reconciliation of equity and net income on a U.S. GAAP basis certified by an officer of the company ~~from inception or for the last 3 years, whichever is less, filed with its domiciliary regulator by the reinsurer or, in the case of a rated group, by the group, pursuant to or including a reconciliation to U.S. GAAP, U.S. Statutory Accounting Principles, or International Financial Property Standards (IFRS); the requirement for 3 years reconciliation shall be waived by the office if the commissioner determines that other provided financial information will be as useful in the determination of financial health of the reinsurer~~;

2. An actuarial opinion as filed with the insurer's domiciliary jurisdiction;

3.~~2.~~ Documentation, in the form of a properly executed Form OIR-C1-2116, which is hereby adopted and incorporated by reference, that the insurer ~~applicant~~ submits to the jurisdiction of the U.S. ~~United States~~ courts, appoints an agent for service of process in Florida, and agrees to post one hundred percent (100%) collateral for its Florida liabilities if it resists enforcement of a valid and final judgment from a court in the United States, or if otherwise required by the Office pursuant to this rule;

4. At the request of the Office, any other regulatory filing made with the insurer's domiciliary jurisdiction;

5.~~3.~~ Form OIR-C1-2117 (for property/casualty) or Form OIR-C1-2118 (for life and health), which are hereby adopted and incorporated by reference. ~~A report that provides information to the office as to its ceded and ceding insurance; the information may be provided in the form of the NAIC Property and Casualty Annual Filing Blank Schedule F, or in any manner that provides the Office with the same information about its ceded and ceding insurance that is disclosed by the NAIC Property and Casualty Annual Filing Blank Schedule F~~;

6.4. A list of all disputed or overdue recoverables due to or claimed by ceding insurers, whether or not the claims are in litigation or arbitration;

7.5. A certification from the domiciliary jurisdiction regulator of the insurer that the company is in good standing and that the domiciliary jurisdiction regulator will provide financial and operational information to the Office; and.

8. Any other information that the Office may reasonably deem appropriate to the application.

(b) Upon receipt of an application for a determination as a certified reinsurer, the Office shall post notice on the Office's website. Such notice shall include instructions on how members of the public may respond to the application. The Office shall not take final action on the application until at least thirty (30) days after posting the notice required by this paragraph.

(c) (b)The determination of eligibility will be made by order issued executed by the Office Commissioner.

(d)(c) To become a certified an eligible reinsurer, the insurer reinsurer, at a minimum:

1. Shall hold surplus in excess of $250 100 million. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250 million and a central fund containing a balance of at least $250 million;

2. Shall be authorized in its domiciliary jurisdiction to assume the kind or kinds of reinsurance ceded by the ceding insurer; and,

3. Shall be domiciled in a qualified an eligible jurisdiction as defined in subsection (9).

(e) Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified

reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:

1. The certified reinsurer's financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in subsection (4) of this rule. The Office shall use the lowest financial strength rating received from a rating agency indicated in subsection (3)(a)-(e) of this rule in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies pursuant to subsection (3) will result in loss of eligibility for certification;

2. The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations;

3. For certified reinsurers domiciled in the U.S., a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers);

4. The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than ninety (90) days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership;

5. Regulatory actions against the certified reinsurer;

6. The liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding; and

7. A certified reinsurer's participation in any solvent schemes of arrangement, or similar procedure, that involves U.S. ceding insurers. A certified reinsurer shall notify the Office prior to participation in a solvent scheme of arrangement.

(f)~~(d)~~ If the Office ~~Commissioner~~ determines, based upon the material submitted, and any other relevant information, that it is in the best interests of market stability and the solvency of ceding insurers, the Office ~~Commissioner~~ will find, by order, that the insurer is a certified ~~an eligible~~ reinsurer and will set an amount of credit allowed for the reinsurer if lower than the amount set forth in subsection (4).

(g) The Office shall publish and maintain a list of certified reinsurers on the Office's website. Such list shall disclose the rating assigned to the certified reinsurer pursuant to subsection (4) of this rule.

(h)~~(e)~~ Every certified ~~eligible~~ reinsurer shall file the following information annually with the Office electronically via the Office's Regulatory Electronic Filing System, "REFS," located at http://www.floir.com/iportal, no later than July 1~~, on the anniversary of the order granting it eligibility~~:

1. Form OIR-C1-2117 (for property/casualty) or Form OIR-C1-2118 (for life and health);

2. The report of the independent auditor on the financial statements of the insurance enterprise, filed on a U.S. GAAP basis. If approved by the Office, the certified reinsurer may provide audited IFRS basis statements so long as a reconciliation of equity and net income are provided on a U.S. GAAP basis. The reconciliation of equity and net income to U.S. GAAP must either be audited or certified by an officer of the company;

3. Actuarial opinion as filed with the certified reinsurer's domiciliary jurisdiction;

4. A statement from the certified reinsurer's domiciliary jurisdiction that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level;

5.~~1.~~ A statement certifying that there has been no change in the provisions of its domiciliary license or any of its financial strength ratings, or a statement describing such changes and the reasons thereforetherefor~~e~~;

6.~~2.~~ At the request of the Office, a copy of any regulatory filings made ~~all financial statements filed~~ with the certified reinsurer's domiciliary jurisdiction ~~their domiciliary regulator~~;

7.~~3.~~ Any change in its directors and officers;

8.~~4.~~ An updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from ~~U.S. domestic~~ ceding insurers; and

9.~~5.~~ Any other information that the Office may require to assure market stability and the solvency of ceding insurers.

(i)~~(f)~~ A certified ~~An eligible~~ reinsurer must ~~immediately~~ advise the Office within ten (10) days of any changes in its ratings assigned by rating agencies, ~~or~~ domiciliary license status, or of any regulatory actions taken against the certified reinsurer. Such notice shall include a statement describing such actions and the reasons therefore.(j)~~(g)~~ At any time, if the Office ~~Commissioner~~ determines that it is in the best interests of market stability and the solvency of ceding insurers, the Office ~~Commissioner~~ will withdraw, by order, any determination of an insurer as a certified ~~an eligible~~ reinsurer or require the certified reinsurer to post additional collateral.

(k)~~(h)~~ If the rating of a certified ~~an eligible~~ reinsurer rises above that used by the Office ~~Commissioner~~ in its ~~his or her~~ determination of the credit allowed for the reinsurer, an affected party may petition the Office ~~Commissioner~~ for a redetermination of the credit allowed. If it is in the best interests of market stability and the solvency of ceding insurers, the Office ~~Commissioner~~ will raise the credit allowed for the certified reinsurer.

(9) Status as a qualified ~~an eligible~~ jurisdiction:

(a) The determination of a jurisdiction as a qualified ~~an eligible~~ jurisdiction is to be made by the Office ~~Commissioner~~. No jurisdiction shall be determined to be a qualified ~~an eligible~~ jurisdiction unless:

1. The insurance regulatory body of the jurisdiction agrees that it will provide information requested by the Office regarding its certified ~~eligible~~ domestic reinsurers;

2. The Office has determined that the jurisdiction has a satisfactory structure and authority with regard to solvency regulation, acceptable financial and operating standards for reinsurers in the domiciliary jurisdiction, acceptable transparent financial reports filed in accordance with generally accepted accounting principles, and verifiable evidence of adequate and prompt enforcement of valid U.S. judgments or arbitration awards;

3. The Office has determined that the history of performance by reinsurers in the jurisdiction is such that the insuring public will be served by a finding of qualification ~~eligibility~~;

4. For non-U.S. jurisdictions, the jurisdiction allows U.S. reinsurers access to the market of the domiciliary jurisdiction on terms and conditions that are at least as favorable as those provided in Florida law and regulations for unaccredited non-U.S. assuming insurers; and

5. There is no other documented information that it would not serve the best interests of the insuring public and the solvency of ceding insurers to make a finding of qualification ~~eligibility~~.

(b) If the NAIC issues findings that certain jurisdictions should be considered qualified ~~eligible~~ jurisdictions, the Office ~~Commissioner~~ shall, if it would serve the best interests of the insuring public and the solvency of ceding insurers, make a determination that jurisdictions on the NAIC list are qualified ~~eligible~~ jurisdictions.

(c) A U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as a qualified jurisdiction.

(d) The Office shall publish a list a jurisdictions that have been determined to be qualified.

(e)~~(c)~~ If the Office ~~Commissioner~~ determines that it is in the best interests of market stability and the solvency of ceding insurers, the Office ~~Commissioner~~ shall withdraw, by order, the determination of a jurisdiction as a qualified ~~an eligible~~ jurisdiction.

(10)(a) If the rating of a certified ~~an eligible~~ reinsurer is below or falls below that required in subsection (4) for the respective amount of credit, the Office shall upon written notice assign a new rating to the certified reinsurer in accordance with subsection (4) of this rule ~~existing credit to the ceding insurer shall be adjusted accordingly~~. Notwithstanding the change or withdrawal of a certified ~~eligible~~ reinsurer's rating, the Office ~~Commissioner~~, upon a determination that the interest of ensuring market stability and the solvency of the ceding insurer requires it, shall, upon request by the ceding insurer, authorize the ceding insurer to continue to take credit for the reinsurance recoverable, or part thereof, relating to the rating change or withdrawal for some specified period of time following such change or withdrawal, unless the reinsurance recoverable is deemed uncollectible.

(b) If the ceding insurer's experience in collecting recoverables from any certified ~~eligible~~ reinsurer indicates that the credit to the ceding insurer should be lower, the ceding insurer shall notify the Oeffice of this.

(c) The Office shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this section, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the Office to reconsider the certified reinsurer's ability or willingness to meet its contractual obligations.

(d) If the rating of a certified reinsurer is upgraded by the Office, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the Office shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the Office, the Office shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.

(e) Upon revocation of the certification of a certified reinsurer by the Office, the assuming insurer shall be required to post security in accordance with Section 624.610, F.S., in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer.

(11) The ceding insurer shall give immediate notice to the Office and provide for the necessary increased reserves with respect to any reinsurance recoverables applicable, in the event:

(a) That obligations of a certified ~~an eligible~~ reinsurer for which credit for reinsurance was taken under this rule are more than ninety (90) days past due and not in dispute; or

(b) That there is any indication or evidence that any certified ~~eligible~~ reinsurer, with whom the ceding insurer has a contract, fails to substantially comply with the solvency requirements under the laws of its domiciliary jurisdiction.

(12) The Office ~~Commissioner~~ shall disallow all or a portion of the credit based on a review of the ceding insurer's reinsurance program, the financial condition of the certified ~~eligible~~ reinsurer, the certified ~~eligible~~ reinsurer's claim payment history, or any other relevant information when such action is in the best interests of market stability and the solvency of the ceding insurer. At any time, the Office ~~Commissioner~~ may request additional information from the certified ~~eligible~~ reinsurer. The failure of a certified ~~an eligible~~ reinsurer to cooperate with the Office is grounds for the Office

~~Commissioner~~ to withdraw the status of the insurer as a certified ~~an eligible~~ reinsurer or for the disallowance or reduction of the credit granted under this rule.

(13)(a) Upon the entry of an order of rehabilitation, liquidation, or conservation against the ceding insurer, pursuant to Chapter 631, Part I, F.S., or the equivalent law of another jurisdiction, a certified ~~an eligible~~ reinsurer, within thirty (30) days of the order, shall fund the entire amount that the ceding insurer has taken, as an asset or deduction from reserves, for reinsurance recoverable from the certified ~~eligible~~ reinsurer. The insurer may request a variance and waiver from this provision as provided by Section 120.542, F.S.

(b) If a certified ~~an eligible~~ reinsurer fails to comply on a timely basis with paragraph (a) of this subsection, the Office ~~Commissioner~~ shall withdraw the reinsurer's certification ~~eligibility~~ under this rule.

(14) The Office ~~Commissioner~~ may, by order, determine that credit shall not be allowed to any ceding insurer for reinsured risk pursuant to this rule if it appears to the Office ~~Commissioner~~ that granting of the credit to the ceding insurer would not be in the public interest or serve the best interests of the ceding insurer's solvency.

(15) Nothing in this rule prohibits a ceding insurer and a reinsurer from entering into agreements establishing collateral requirements in excess of those set forth in this rule.

(16) A ceding insurer shall notify the Office within thirty (30) days after reinsurance recoverables from any single assuming insurer, or group of assuming insurers, exceeds fifty percent (50%) of the ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(17) A ceding insurer shall notify the Office within thirty (30) days after ceding to any single assuming insurer, or group of assuming insurers, more than twenty percent (20%) of the ceding insurer's gross written premium in the prior calendar year, or after it is determined that the reinsurance ceded to any single assuming insurer, or group of assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the ceding insurer.

(18) Forms adopted in this rule are available on the Office's web site located at http://www.floir.com.

Specific Authority 624.308, 624.610(14) FS. Law Implemented 624.307(1), 624.610 FS. History–New 10-29-08, Amended _____.

FORM CR-1

CERTIFICATE OF CERTIFIED REINSURER

I, _____, _____
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)

under a reinsurance agreement with one or more insurers domiciled in _____,
in order to be considered for approval in this state, hereby certify that (name of state)

_____("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in _____
(ceding insurer's state of domicile)
for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.

2. Designates the Insurance Commissioner of _____
(ceding insurer's state of domicile)
as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.

3. Agrees to provide security in an amount equal to 100% of liabilities attributable to U.S. ceding insurers if it resists enforcement of a final U.S. judgment or properly enforceable arbitration award.

4. Agrees to provide notification within 10 days of any regulatory actions taken against it, any change in the provisions of its domiciliary license or any change in its rating by an approved rating agency, including a statement describing such changes and the reasons therefore.

5. Agrees to annually file information comparable to relevant provisions of the NAIC financial statement for use by insurance markets in accordance with Rule 69O-144.007(8)(h), F.A.C..

6. Agrees to annually file the report of the independent auditor on the financial statements of the insurance enterprise.

7. Agrees to annually file audited financial statements, regulatory filings, and actuarial opinion in accordance with Rule 69O-144.007(8)(h), F.A.C..

8. Agrees to annually file an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers.

9. Is in good standing as an insurer or reinsurer with the supervisor of its domiciliary jurisdiction.

Dated: _____

_____
(name of assuming insurer)

BY: _____
(name of officer)

_____
(title of officer)

FORM CR-F

INDEX

FORM CR-F – PART 1

ASSUMED REINSURANCE – PROPERTY/CASUALTY BUSINESS AS OF DECEMBER 31 (MOST RECENT YEAR-END)

Form CR-F Part 1 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-F must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 1 provides information with respect to reinsurance assumed by the Certified Reinsurer (or applicant) from ceding insurers domiciled in the U.S. and abroad. Part 1 data may be reported on an aggregate basis as opposed to reporting data applicable to each individual ceding insurer. However, reporting entities are required to segregate and subtotal this aggregate information in accordance with the categories listed below, as applicable.*

*Note: Additional Instructions for Assuming Insurers Subject to Filing Schedule F Part 1 of the NAIC Annual Statement – In certain cases, a non-U.S. domiciled assuming insurer is required to file annually a Schedule F Part 1 from the NAIC Annual Statement. The Schedule F Part 1 filing is submitted to a U.S. state in which the assuming insurer maintains a trust fund in a qualified U.S. financial institution for the payment of the valid claims of its U.S. ceding insurers with respect to U.S. reinsurance it has assumed under a status other than as a Certified Reinsurer. The purpose of the Schedule F Part 1 filing is to enable the commissioner of the state in which the trust is domiciled to determine the sufficiency of the trust fund, and its Form CR-F filing does not affect this Schedule F Part 1 filing requirement. The assuming insurer's Schedule F Part 1 should only include U.S. reinsurance it has assumed that is supported by this trust.

In such cases, the assuming insurer may exclude from Form CR-F Part 1 U.S. reinsurance assumed that is reported in its Schedule F Part 1. However, the assuming insurer must attach a copy of its Schedule F Part 1 filing with its Form CR-F, and must clearly indicate on Form CR-F Part 1 that its U.S. reinsurance assumed is reported in this manner (i.e., its Form CR-F Part 1 includes non-U.S. reinsurance assumed and U.S. reinsurance assumed under its Certified Reinsurer status, while its attached Schedule F Part 1 includes U.S. reinsurance it has assumed under a status other than as a Certified Reinsurer).

Group or Category	Line Number
Reinsurance Assumed from Affiliated Ceding Insurers	
U.S. Affiliated	0199999
Non-U.S. Affiliated	0299999
Total Affiliated	0399999
Reinsurance Assumed from Unaffiliated Ceding Insurers	
U.S. Unaffiliated	0499999
Non-U.S. Unaffiliated	0599999
Total Unaffiliated	0699999
Total Reinsurance Assumed	0799999

Column Descriptions

Column 5 – Assumed Reinsurance Premium

Column 6 – Reinsurance on Paid Losses and Loss Adjustment Expenses (LAE)

Report losses and loss adjustment expenses due and payable to ceding insurers.

Column 7 – Reinsurance on Known Case Losses and LAE

Report known case reserves for losses and LAE assumed from ceding insurers.

Column 8 – Totals of Columns 6 + 7 for each category.

Column 9 – Contingent Commissions Payable

Report profit commissions generated from assumed reinsurance contracts due to ceding insurers. Report commissions net of return profit commissions. Negative commissions are possible, (i.e., when a contingent commission is receivable.)

Column 10 – Assumed Premiums Receivable

Report receivable amounts net of commissions payable

.

Column 12 – Funds Held By or Deposited with Reinsured Companies

Column 13 – Letters of Credit Posted

Column 14 – Amount of Assets Pledged or Compensating Balances to Secure Letters of Credit

Column 15 – Amount of Assets Pledged or Collateral Held in Trust

This column reflects amounts that are not otherwise reflected in Column 12 of this schedule that are under the control of ceding insurance companies.

FORM CR-F – PART 2

CEDED REINSURANCE – PROPERTY/CASUALTY BUSINESS AS OF DECEMBER 31 (MOST RECENT YEAR-END)

Form CR-F Part 2 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-F must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 2 provides information with respect to reinsurance ceded or retroceded by a Certified Reinsurer (or applicant) to assuming insurers domiciled in the U.S. and abroad. Reporting entities are required to provide assuming insurer-specific data on reinsurance ceded for a minimum of the top ten assuming insurers as measured by reinsurance recoverables. Assuming insurer-specific data must be reported for additional assuming insurers (i.e., beyond the top ten) only to the extent necessary to ensure that the assuming insurer-specific reporting represents at least 75% of all reinsurance recoverables due. Only Columns 1, 3, 4, 6 and 15 (in total) are required to be completed with respect to the assuming insurer-specific data applicable to the top ten assuming insurers (or additional assuming insurers to meet 75% minimum). Part 2 data applicable to all other assuming insurers may be reported on an aggregate basis; however, each of the columns from 6 through 19 must be completed for the aggregated data. Reporting entities are required to subtotal this information, including both individual and aggregate data, into the categories listed below, as applicable.

Group or Category	Line Number
Reinsurance Ceded/Retroceded to Affiliated Assuming Insurers	
U.S. Affiliated	0199999
Non-U.S. Affiliated	0299999
Total Affiliated	0399999
Reinsurance Ceded/Retroceded to Unaffiliated Assuming Insurers	
U.S. Unaffiliated	0499999
Non-U.S. Unaffiliated	0599999
Total Unaffiliated	0699999
Total Reinsurance Ceded	0799999

Column Descriptions

Column 1 – Company Code or ID Number

The U.S. Federal Employer Identification Number (FEIN) must be reported for each U.S. domiciled insurer and U.S. branch of an alien insurer. For insurers domiciled in non-U.S. jurisdictions, report the entity's national identification number as issued by its domestic jurisdiction. Reinsurance intermediaries should not be listed, as Form CR-F is intended to identify only risk-bearing entities.

Column 3 – Name of Reinsurer

Column 4 – Domiciliary Jurisdiction

Report the two-character postal code abbreviation for the domiciliary jurisdiction. A comprehensive listing of postal code abbreviations for foreign countries is attached to these instructions. For postal code abbreviations of foreign countries not found in the appendix, use the code found at:

www.nationsonline.org/oneworld/countrycodes.htm

If a reinsurer has merged with another entity, report the domiciliary jurisdiction of the surviving entity.

Column 5 – Reinsurance Contracts Ceding 75% or More Direct Premiums Written

For the data reported by individual assuming insurer, a separate entry should be made to identify each individual contract (except those listed under "Exceptions" below) which provides for the cession of 75% or more of direct or assumed premiums written by the reporting entity under such cession during the year. Such line item entries should be identified by inserting a 2 in this column. The reinsurance transactions so identified shall include both treaty and facultative cessions of direct or assumed business written by the reporting entity.

Exceptions: Intercompany reinsurance transactions with affiliates.

Reinsurance transactions involving any group, association, pool, or organization of insurers that engage in joint underwriting activities and which are subject to examination by any state regulatory authority or which operate pursuant to any state or federal statutory or administrative authorization.

Any reinsurance transaction in which the annual gross premium ceded is less than 5% of policyholder surplus.

Reinsurance transactions involving captive insurance companies.

Column 6 – Reinsurance Premiums Ceded

Column 7 – Reinsurance Recoverable on Paid Losses

Column 8 – Reinsurance Recoverable on Paid LAE

Column 9 – Reinsurance Recoverable on Known Case Loss Reserves

Column 10 – Reinsurance Recoverable on Known Case LAE Reserves

Column 11 – Reinsurance Recoverable on IBNR Loss Reserves

Column 13 – Reinsurance Recoverable on Unearned Premiums

Column 14 – Contingent Commissions

Include: Contingent commissions receivable from a reinsurer. Regular commissions should be netted with ceded balances payable in Column 16.

If Column 14 is less than zero, report the amount in Column 17.

Column 15 – Total Columns 7 through 14

Column 16 – Ceded Balances Payable

Column 17 – Other Amounts Due to Reinsurers

Both Column 16 and Column 17 are liabilities owed to the reinsurer.

Deduct: Reinsurance premiums paid by a ceding company prior to the effective date of the contract.

Exclude: Funds held by company under reinsurance treaties, which are included in Column 19.

Items entered in Column 17 may represent miscellaneous balances owed by the reinsured to the reinsurer on ceded transactions.

Column 18 – Net Amount Recoverable from Reinsurers

Column 19 – Funds Held By Company Under Reinsurance Treaties

Form CR-F PART 1

Assumed Reinsurance as of December 31, Current Year (000 Omitted)

1	2	3	4	5	Reinsurance On			9	10	11	12	13	14	15
					6	7	8							
Company Code or ID Number		Name of Reinsured	Domiciliary Jurisdiction	Assumed Premium	Paid Losses and Loss Adjustment Expenses	Known Case Losses and LAE	Cols. 6 + 7	Contingent Commissions Payable	Assumed Premiums Receivable	Unearned Premium	Funds Held By or Deposited With Reinsured Companies	Letters of Credit Posted	Amount of Assets Pledged or Compensating Balances to Secure Letters of Credit	Amount of Assets Pledged or Collateral Held in Trust
9999999 Totals														

Form CR-F – PART 2

Ceded Reinsurance as of December 31, Current Year (000 Omitted)

1	2	3	4	5	6	Reinsurance Recoverable On									Reinsurance Payable		18	19
						7	8	9	10	11	12	13	14	15	16	17		
Company Code or ID Number		Name of Reinsurer	Domiciliary Jurisdiction	Reinsurance Contracts Ceding 75% or More of Direct Premiums Written	Reinsurance Premiums Ceded	Paid Losses	Paid LAE	Known Case Loss Reserves	Known Case LAE Reserves	IBNR Loss Reserves	IBNR LAE Reserves	Unearned Premiums	Contingent Commissions	Cols. 7 through 14 Totals	Ceded Balances Payable	Other Amounts Due to Reinsurers	Net Amount Recoverable From Reinsurers Cols. 15 – [16 + 17]	Funds Held by Company Under Reinsurance Treaties
9999999 Totals																		

FORM CR-S

INDEX

FORM CR-S – PART 1 – SECTION 1

REINSURANCE ASSUMED LIFE INSURANCE, ANNUITIES, DEPOSIT FUNDS AND OTHER LIABILITIES WITHOUT LIFE OR DISABILITY CONTINGENCIES, AND RELATED BENEFITS LISTED BY REINSURED COMPANY AS OF DECEMBER 31, (MOST RECENT YEAR-END)

Form CR-S Part 1, Section 1 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-S must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 1, Section 1 provides information on all reinsurance assumed for life insurance, annuities, deposit fund and other liabilities without life or disability contingencies, and related benefits from ceding insurers domiciled in the U.S. and abroad. Part 1, Section 1 data may be reported on an aggregate basis as opposed to reporting data applicable to each individual ceding insurer. However, reporting entities are required to segregate and subtotal this aggregate information in accordance with the categories listed below, as applicable.*

*Note: Additional Instructions for Assuming Insurers Subject to Filing Schedule S Part 1 of the NAIC Annual Statement –
In certain cases, a non-U.S. domiciled assuming insurer is required to file annually a Schedule S Part 1 from the NAIC Annual Statement. The Schedule S Part 1 filing is submitted to a U.S. state in which the assuming insurer maintains a trust fund in a qualified U.S. financial institution for the payment of the valid claims of its U.S. ceding insurers with respect to U.S. reinsurance it has assumed under a status other than as a Certified Reinsurer. The purpose of the Schedule S Part 1 filing is to enable the commissioner of the state in which the trust is domiciled to determine the sufficiency of the trust fund, and its Form CR-S filing does not affect this Schedule S Part 1 filing requirement. The assuming insurer's Schedule S Part 1 should only include U.S. reinsurance it has assumed that is supported by this trust.

In such cases, the assuming insurer may exclude from Form CR-S Part 1 U.S. reinsurance assumed that is reported in its Schedule S Part 1. However, the assuming insurer must attach a copy of its Schedule S Part 1 filing with its Form CR-S, and must clearly indicate on Form CR-S Part 1 that its U.S. reinsurance assumed is reported in this manner (i.e., its Form CR-S Part 1 includes non-U.S. reinsurance assumed and U.S. reinsurance assumed under its Certified Reinsurer status, while its attached Schedule s Part 1 includes U.S. reinsurance it has assumed under a status other than as a Certified Reinsurer).

Group or Category	Line Number
General Account	
Affiliates	
U.S. Affiliates	0199999
Non-U.S. Affiliates	0299999
Total Affiliates	0399999
Non-Affiliates	
U.S. Non-Affiliates	0499999
Non-U.S. Non-Affiliates	0599999
Total Non-Affiliates	0699999
Total General Account	0799999
Separate Accounts	
Affiliates	
U.S. Affiliates	0899999
Non-U.S. Affiliates	0999999
Total Affiliates	1099999
Non-Affiliates	
U.S. Non-Affiliates	1199999
Non-U.S. Non-Affiliates	1299999
Total Non-Affiliates	1399999

Total Separate Accounts.....1499999
Total U.S. (Sum of 0199999, 0499999, 0899999, 1199999).....1599999
Total Non-U.S. (Sum of 0299999, 0599999, 0999999, 1299999).....1699999
Total (Sum of 1599999 and 1699999).....1799999

Column Descriptions

Column 7 – Amount in Force at End of Year

For catastrophe-reinsurance (CAT), disability reinsurance (DIS), accidental death benefit reinsurance (ADB) and annuity reinsurance (ACO and AMCO), leave this column blank.

Column 9 – Premiums

For deposit funds and other liabilities without life or disability contingencies, leave this column blank.

Column 10 – Reinsurance Payable on Paid and Unpaid Losses

For deposit funds and other liabilities without life or disability contingencies, leave this column blank.

Column 11 – Modified Coinsurance Reserve

Report the amount of reserves held by the ceding company under modified coinsurance contracts. Include separate accounts modified coinsurance reserves.

Column 12 – Funds Withheld Under Coinsurance

Report the amount of funds withheld by the ceding company on coinsurance contracts.

FORM CR-S – PART 1 – SECTION 2

REINSURANCE ASSUMED ACCIDENT AND HEALTH INSURANCE LISTED BY REINSURED COMPANY AS OF DECEMBER 31, (MOST RECENT YEAR-END)

Form CR-S Part 1, Section 2 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-S must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 1, Section 2 provides information on all reinsurance assumed for accident and health insurance from ceding insurers domiciled in the U.S. and abroad. Amounts are to be reported in U.S. dollars with thousands omitted. Part 1, Section 2 data may be reported on an aggregate basis as opposed to reporting data applicable to each individual ceding insurer. However, reporting entities are required to segregate and subtotal this aggregate information in accordance with the categories listed below, as applicable.*

*Note: Additional Instructions for Assuming Insurers Subject to Filing Schedule S Part 1 of the NAIC Annual Statement – In certain cases, a non-U.S. domiciled assuming insurer is required to file annually a Schedule S Part 1 from the NAIC Annual Statement. The Schedule S Part 1 filing is submitted to a U.S. state in which the assuming insurer maintains a trust fund in a qualified U.S. financial institution for the payment of the valid claims of its U.S. ceding insurers with respect to U.S. reinsurance it has assumed under a status other than as a Certified Reinsurer. The purpose of the Schedule S Part 1 filing is to enable the commissioner of the state in which the trust is domiciled to determine the sufficiency of the trust fund, and its Form CR-S filing does not affect this Schedule S Part 1 filing requirement. The assuming insurer's Schedule S Part 1 should only include U.S. reinsurance it has assumed that is supported by this trust.

In such cases, the assuming insurer may exclude from Form CR-S Part 1 U.S. reinsurance assumed that is reported in its Schedule S Part 1. However, the assuming insurer must attach a copy of its Schedule S Part 1 filing with its Form CR-S, and must clearly indicate on Form CR-S Part 1 that its U.S. reinsurance assumed is reported in this manner (i.e., its Form CR-S Part 1 includes non-U.S. reinsurance assumed and U.S. reinsurance assumed under its Certified Reinsurer status, while its attached Schedule s Part 1 includes U.S. reinsurance it has assumed under a status other than as a Certified Reinsurer).

Group or Category	Line Number
Reinsurance Assumed from Affiliated Ceding Insurers	
U.S. Affiliated	0199999
Non-U.S. Affiliated	0299999
Total Affiliated	0399999
Reinsurance Assumed from Unaffiliated Ceding Insurers	
U.S. Unaffiliated	0499999
Non-U.S. Unaffiliated	0599999
Total Unaffiliated	0699999
Total Reinsurance Assumed	0799999

Column Descriptions

Column 7 – Assumed Reinsurance Premiums

Column 8 – Unearned Assumed Reinsurance Premiums

Column 9 – Reserve Liability Other Than For Unearned Premiums

Column 10 – Reinsurance Payable on Paid and Unpaid Losses

Column 11 – Modified Coinsurance Reserve

Report the amount of the reserves held by the ceding company under modified coinsurance contracts.

Column 12 – Funds Withheld Under Coinsurance

Report the amount of funds withheld by the ceding company on coinsurance contracts.

FORM CR-S – PART 2

REINSURANCE RECOVERABLE ON PAID AND UNPAID LOSSES AS OF DECEMBER 31, (MOST RECENT YEAR-END)

Form CR-S Part 2 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-S must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 2 provides information with respect to reinsurance recoverable on paid and unpaid losses from assuming insurers domiciled in the U.S. and abroad. Reporting entities are required to provide assuming insurer-specific data on reinsurance ceded for a minimum of the top ten assuming insurers as measured by reinsurance recoverables. Assuming insurer-specific data must be reported for additional assuming insurers (i.e., beyond the top ten) only to the extent necessary to ensure that the assuming insurer-specific reporting represents at least 75% of all reinsurance recoverables due. Reporting entities are required to subtotal this information, including both individual and aggregate data, into the categories listed below, as applicable.

Group or Category	Line Number
Life and Annuity	
Affiliates	
U.S. Affiliates	0199999
Non-U.S. Affiliates	0299999
Total Affiliates	0399999
Non-Affiliates	
U.S. Non-Affiliates	0499999
Non-U.S. Non-Affiliates	0599999
Total Non-Affiliates	0699999
Total Life and Annuity	0799999
Accident and Health	
Affiliates	
U.S. Affiliates	0899999
Non-U.S. Affiliates	0999999
Total Affiliates	1099999
Non-Affiliates	
U.S. Non-Affiliates	1199999
Non-U.S. Non-Affiliates	1299999
Total Non-Affiliates	1399999
Total Accident and Health	1499999
Total U.S. (Sum of 0199999, 0499999, 0899999 and 1199999)	1599999
Total Non-U.S. (Sum of 0299999, 0599999, 0999999 and 1299999)	1699999
Total (Sum of 1599999 and 1699999)	1799999

Column Descriptions

Column 1 – Company Code or ID Number

The U.S. Federal Employer Identification Number (FEIN) must be reported for each U.S. domiciled insurer and U.S. branch of an alien insurer. For insurers domiciled in non-U.S. jurisdictions, report the

entity's national identification number as issued by its domestic jurisdiction. Reinsurance intermediaries should not be listed, as Form CR-F is intended to identify only risk-bearing entities.

Column 3 – Effective Date

Report earliest effective date of contracts with recoverables reported applicable to individual assuming insurers.

Column 4 – Name of Company (Reinsurer)

Column 5 – Location (Domiciliary Jurisdiction)

Report the two-character postal code abbreviation for the domiciliary jurisdiction. A comprehensive listing of postal code abbreviations for foreign countries is attached to these instructions. For postal code abbreviations of foreign countries not found in the appendix, use the code found at:

www.nationsonline.org/oneworld/countrycodes.htm

If a reinsurer has merged with another entity, report the domiciliary jurisdiction of the surviving entity.

Column 6 – Paid Losses

Report reinsured claim amounts paid by the reporting entity but not yet reimbursed by the reinsurer.

Column 7 – Unpaid Losses

Include the reinsured amounts for claims that are in course of settlement and will become recoverable from reinsurers following payment.

FORM CR-S – PART 3 – SECTION 1

REINSURANCE CEDED LIFE INSURANCE, ANNUITIES, DEPOSIT FUNDS AND OTHER LIABILITIES WITHOUT LIFE OR DISABILITY CONTINGENCIES, AND RELATED BENEFITS AS OF DECEMBER 31, (MOST RECENT YEAR-END)

Form CR-S Part 3 Section 1 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-S must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 3 Section 1 provides information with respect to reinsurance ceded or retroceded by a Certified Reinsurer (or applicant) to assuming insurers domiciled in the U.S. and abroad. Reporting entities are required to provide assuming insurer-specific data on reinsurance ceded for a minimum of the top ten assuming insurers as measured by reinsurance recoverables. Assuming insurer-specific data must be reported for additional assuming insurers (i.e., beyond the top ten) only to the extent necessary to ensure that the assuming insurer-specific reporting represents at least 75% of all reinsurance recoverables due. Part 3 Section 1 data applicable to all other assuming insurers may be reported on an aggregate basis. Reporting entities are required to subtotal this information, including both individual and aggregate data, into the categories listed below, as applicable. Include actual reinsurance ceded on group cases but exclude jointly underwritten group contracts.

Group or Category	Line Number
General Account	
Affiliates	
U.S. Affiliates	0199999
Non-U.S. Affiliates	0299999
Total Affiliates	0399999
Non-Affiliates	
U.S. Non-Affiliates	0499999
Non-U.S. Non-Affiliates	0599999
Total Non-Affiliates	0699999
Total General Account	0799999
Separate Accounts	
Affiliates	
U.S. Affiliates	0899999
Non-U.S. Affiliates	0999999
Total Affiliates	1099999
Non-Affiliates	
U.S. Non-Affiliates	1199999
Non-U.S. Non-Affiliates	1299999
Total Non-Affiliates	1399999
Total Separate Accounts	1499999
Total U.S. (Sum of 0199999, 0499999, 0899999, 1199999)	1599999
Total Non-U.S. (Sum of 0299999, 0599999, 0999999, 1299999)	1699999
Total (Sum of 1599999 and 1699999)	1799999

Column Descriptions

Column 1 – Company Code or ID Number

The U.S. Federal Employer Identification Number (FEIN) must be reported for each U.S. domiciled insurer and U.S. branch of an alien insurer. For insurers domiciled in non-U.S. jurisdictions, report the

entity's national identification number as issued by its domestic jurisdiction. Reinsurance intermediaries should not be listed, as Form CR-F is intended to identify only risk-bearing entities.

Column 3 – Effective Date

Report earliest effective date of contracts with recoverables reported applicable to individual assuming insurers.

Column 4 – Name of Company (Reinsurer)

Column 5 – Location (Domiciliary Jurisdiction)

Report the two-character postal code abbreviation for the domiciliary jurisdiction. A comprehensive listing of postal code abbreviations for foreign countries is available in the appendix of these instructions. For postal code abbreviations of foreign countries not found in the appendix, use the code found at:

www.nationsonline.org/oneworld/countrycodes.htm

If a reinsurer has merged with another entity, report the domiciliary jurisdiction of the surviving entity.

Column 6 – Type of Reinsurance Ceded

Use the following abbreviations to identify the plan and type of reinsurance. For example, group coinsurance with funds withheld should be identified as COFW/G. (If there is more than one type of reinsurance in the same reinsurance company, show each type on a separate line.) NOTE: The type should be entered in all capital letters, and ALL reinsurance types must be followed by /G (for Group) or /I (for Individual).

Abbreviations:

I	Individual
G	Group

{ All Reinsurance Types should be followed by /I or /G.

REINSURANCE TYPES

CO	Coinsurance	ACO	Annuity coinsurance
COFW	Coinsurance with funds withheld	ACOFW	Annuity coinsurance with funds withheld
MCO	Modified coinsurance	AMCO	Annuity modified coinsurance
MCOFW	Modified coinsurance with funds withheld	AMCOFW	Annuity modified coinsurance with funds withheld
COMB	Combination coinsurance/modified coinsurance	ACOMB	Annuity combination coinsurance/modified coinsurance
COMBW	Combination coinsurance/modified coinsurance with funds withheld	ACOMBW	Annuity combination coinsurance/modified coinsurance with funds withheld
YRT	Yearly renewable term	GMDB	Guaranteed minimum death benefit
CAT	Catastrophe	GMDBFW	Guaranteed minimum death benefit funds withheld
OTH	Other reinsurance	ADB	Accidental death benefit
		DIS	Disability benefits

NOTE: The insurance type should be entered in all capital letters.

Column 7 – Amount in Force at End of Year

Report the ceded amount of the basic life insurance policy only

For catastrophe-reinsurance (CAT), disability reinsurance (DIS), accidental death benefit reinsurance (ADB) and annuity reinsurance (ACO and AMCO), leave this column blank.

Column 8 – Reserve Credit Taken Current Year

Column 9 – Reserve Credit Taken Prior Year

Column 10 – Premiums

Amounts included in this column should represent reinsurance ceded premiums on an incurred basis.

For deposit funds and other liabilities without life or disability contingencies, leave this column blank.

Columns 11 & 12 – Outstanding Surplus Relief

Outstanding surplus relief means the amount of surplus not yet reported as income.

Report the amount of initial commissions and expense allowance not yet recovered by the reinsurer for the following types of treaties (individual or group): CO, ACO, MCO, AMCO, COFW, ACOFW, MCOFW, AMCOFW, COMB, ACOMB, ACOMBW AND COMBW. This column does not apply to CAT, DIS, ADB, YRT or other non-proportional reinsurance treaties.

Include the outstanding surplus resulting from reinsurance of separate accounts business.

Column 13 – Modified Coinsurance Reserve

Report the amount of reserves held under modified coinsurance contracts. Include separate accounts modified coinsurance reserves.

Column 14 – Funds Withheld Under Coinsurance

Report the amount of funds withheld on coinsurance contracts.

FORM CR-S – PART 3 – SECTION 2

REINSURANCE CEDED ACCIDENT AND HEALTH INSURANCE AS OF DECEMBER 31, (MOST RECENT YEAR-END)

Form CR-S Part 3 Section 1 must be reported by an assuming insurer upon initial application for status as a Certified Reinsurer, and on an annual basis thereafter so long as the Certified Reinsurer maintains certification. Amounts are to be reported in U.S. dollars with thousands omitted. All dates reported in Form CR-S must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011. The Certified Reinsurer's rating and collateral requirement, as assigned by the certifying state, and the effective date of such rating, must be included on this form with respect to each filing that is submitted subsequent to certification.

Part 3 Section 1 provides information with respect to reinsurance ceded or retroceded by a Certified Reinsurer (or applicant) to assuming insurers domiciled in the U.S. and abroad. Reporting entities are required to provide assuming insurer-specific data on reinsurance ceded for a minimum of the top ten assuming insurers as measured by reinsurance recoverables. Assuming insurer-specific data must be reported for additional assuming insurers (i.e., beyond the top ten) only to the extent necessary to ensure that the assuming insurer-specific reporting represents at least 75% of all reinsurance recoverables due. Part 3 Section 1 data applicable to all other assuming insurers may be reported on an aggregate basis. Reporting entities are required to subtotal this information, including both individual and aggregate data, into the categories listed below, as applicable. Include actual reinsurance ceded on group cases but exclude jointly underwritten group contracts.

Group or Category	Line Number
General Account	
Affiliates	
U.S. Affiliates	0199999
Non-U.S. Affiliates	0299999
Total Affiliates	0399999
Non-Affiliates	
U.S. Non-Affiliates	0499999
Non-U.S. Non-Affiliates	0599999
Total Non-Affiliates	0699999
Total General Account	0799999
Separate Accounts	
Affiliates	
U.S. Affiliates	0899999
Non-U.S. Affiliates	0999999
Total Affiliates	1099999
Non-Affiliates	
U.S. Non-Affiliates	1199999
Non-U.S. Non-Affiliates	1299999
Total Non-Affiliates	1399999
Total Separate Accounts	1499999
Total U.S. (Sum of 0199999, 0499999, 0899999, 1199999)	1599999
Total Non-U.S. (Sum of 0299999, 0599999, 0999999, 1299999)	1699999
Total (Sum of 1599999 and 1699999)	1799999

Column Descriptions

Column 1 – Company Code or ID Number

The U.S. Federal Employer Identification Number (FEIN) must be reported for each U.S. domiciled insurer and U.S. branch of an alien insurer. For insurers domiciled in non-U.S. jurisdictions, report the entity's national identification number as issued by its domestic jurisdiction. Reinsurance intermediaries should not be listed, as Form CR-F is intended to identify only risk-bearing entities.

Column 3 – Effective Date

Report earliest effective date of contracts with recoverables reported applicable to individual assuming insurers.

Column 4 – Name of Company (Reinsurer)

Column 5 – Location (Domiciliary Jurisdiction)

Report the two-character postal code abbreviation for the domiciliary jurisdiction. A comprehensive listing of postal code abbreviations for foreign countries is available in the appendix of these instructions. For postal code abbreviations of foreign countries not found in the appendix, use the code found at:

www.nationsonline.org/oneworld/countrycodes.htm

If a reinsurer has merged with another entity, report the domiciliary jurisdiction of the surviving entity.

Column 6 – Type

Use the following abbreviations to identify the plan and type of reinsurance. For example, group coinsurance with funds withheld should be identified as COFW/G. (If there is more than one type of reinsurance in the same reinsurance company, show each type on a separate line.) NOTE: The type should be entered in all capital letters, and ALL reinsurance types must be followed by /G (for Group) or /I (for Individual).

Abbreviations:

I	Individual	{ All Reinsurance Types should be followed by /I or /G.
G	Group	

REINSURANCE TYPES

CO	Coinsurance	COFW	Coinsurance with funds withheld
MCO	Modified coinsurance	MCOFW	Modified coinsurance with funds withheld
COMB	Combination coinsurance/modified coinsurance	COMBW	Combination coinsurance/modified coinsurance with funds withheld
YRT	Yearly renewable term	CAT	Catastrophe
LTC	Long-Term Care	OTH	Other reinsurance

NOTE: The insurance type should be entered in all capital letters.

Column 7 – Premiums

Amounts included in this column should represent reinsurance ceded premiums on an incurred basis.

Column 8 – Unearned Premiums (Estimated)

Amounts represent, by company, the ceded part of the unearned premium.

Column 9 – Reserve Credit Taken Other Than For Unearned Premiums

Columns 10 and 11 – Outstanding Surplus Relief

Outstanding surplus relief means the amount of surplus not yet reported as income.

Report the amount of initial commissions and expense allowance not yet recovered by the reinsurer for the following types of treaties (individual or group): CO, MCO, COFW, MCOFW, COMB or COMBW. This column does not apply to YRT or other nonproportional reinsurance treaties.

Column 12 – Modified Coinsurance Reserve

Report the amount of reserves held under modified coinsurance contracts.

Column 13 – Funds Withheld Under Coinsurance

Report the amount of funds withheld on coinsurance contracts.

Form CR-S – PART 1 – SECTION 1

Reinsurance Assumed Life Insurance, Annuities, Deposit Funds and Other Liabilities
Without Life or Disability Contingencies, and Related Benefits Listed by Reinsured Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Reinsured	5 Location	6 Type of Reinsurance Assumed	7 Amount of In Force at End of Year	8 Reserve	9 Premiums	10 Reinsurance Payable on Paid and Unpaid Losses	11 Modified Coinsurance Reserve	12 Funds Withheld Under Coinsurance
Totals											

Form CR-S – PART 1 – SECTION 2

Reinsurance Assumed Accident and Health Insurance Listed by Reinsured Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Reinsured	5 Domiciliary Jurisdiction	6 Type of Reinsurance Assumed	7 Premiums	8 Unearned Premiums	9 Reserve Liability Other Than For Unearned Premiums	10 Reinsurance Payable on Paid and Unpaid Losses	11 Modified Coinsurance Reserve	12 Funds Withheld Under Coinsurance
Totals											

NAIC Form CR-S
OIR-C1-2118 (New XX/XX)
Rule 69O-144.007

Form CR-S – PART 2

Reinsurance Recoverable on Paid and Unpaid Losses Listed by Reinsuring Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Company	5 Location	6 Paid Losses	7 Unpaid Losses
Totals—Life, Annuity and Accident and Health						

Form CR-S – PART 3 – SECTION 1

Reinsurance Ceded Life Insurance, Annuities, Deposit Funds and Other Liabilities
Without Life or Disability Contingencies, and Related Benefits Listed by Reinsuring Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Company	5 Location	6 Type of Reinsurance Ceded	7 Amount in Force at End of Year	Reserve Credit Taken		10 Premiums	Outstanding Surplus Relief		13 Modified Coinsurance Reserve	14 Funds Withheld Under Coinsurance
							8 Current Year	9 Prior Year		11 Current Year	12 Prior Year		
Totals													

Form CR-S – PART 3 – SECTION 2

Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year

1	2	3	4	5	6	7	8	9	Outstanding Surplus Relief		12	13
Company Code or ID Number		Effective Date	Name of Company	Location	Type	Premiums	Unearned Premiums (Estimated)	Reserve Credit Taken Other than for Unearned Premiums	10 Current Year	11 Prior Year	Modified Coinsurance Reserve	Funds Withheld Under Coinsurance
Totals												

69O-144.005,.007
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.
624.610 Reinsurance.—
(1) The purpose of this section is to protect the interests of insureds, claimants, ceding insurers, assuming insurers, and the public. It is the intent of the Legislature to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislature requires that upon the insolvency of a non-United States insurer or reinsurer which provides security to fund its United States obligations in accordance with this section, such security shall be maintained in the United States and claims shall be filed with and valued by the state insurance regulator with regulatory oversight, and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies. The Legislature declares that the matters contained in this section are fundamental to the business of insurance in accordance with 15 U.S.C. ss. 1011-1012.
(2) Credit for reinsurance must be allowed a ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of paragraph (3)(a), paragraph (3)(b), or paragraph (3)(c). Credit must be allowed under paragraph (3)(a) or paragraph (3)(b) only for cessions of those kinds or lines of business that the assuming insurer is licensed, authorized, or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed or authorized to transact insurance or reinsurance.
(3)(a) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is authorized to transact insurance or reinsurance in this state.
(b)1. Credit must be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state. An accredited reinsurer is one that:
a. Files with the office evidence of its submission to this state's jurisdiction;
b. Submits to this state's authority to examine its books and records;
c. Is licensed or authorized to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through, licensed, or authorized to transact insurance or reinsurance in at least one state;
d. Files annually with the office a copy of its annual statement filed with the insurance department of its state of domicile any quarterly statements if required by its state of domicile or such quarterly statements if specifically requested by the office, and a copy of its most recent audited financial statement; and
(I) Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has not been denied by the office within 90 days after its submission; or
(II) Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has been approved by the office.
2. The office may deny or revoke an assuming insurer's accreditation if the assuming insurer does not submit the required documentation pursuant to subparagraph 1., if the assuming insurer fails to meet all of the standards required of an accredited reinsurer, or if the assuming insurer's accreditation would be hazardous to the policyholders of this state. In determining whether to deny or revoke accreditation, the office may consider the qualifications of the assuming insurer with respect to all the following subjects:
a. Its financial stability;

b. The lawfulness and quality of its investments;
c. The competency, character, and integrity of its management;
d. The competency, character, and integrity of persons who own or have a controlling interest in the assuming insurer; and
e. Whether claims under its contracts are promptly and fairly adjusted and are promptly and fairly paid in accordance with the law and the terms of the contracts.
3. Credit must not be allowed a ceding insurer if the assuming insurer's accreditation has been revoked by the office after notice and the opportunity for a hearing.
4. The actual costs and expenses incurred by the office to review a reinsurer's request for accreditation and subsequent reviews must be charged to and collected from the requesting reinsurer. If the reinsurer fails to pay the actual costs and expenses promptly when due, the office may refuse to accredit the reinsurer or may revoke the reinsurer's accreditation.
(c)1. Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in paragraph (5)(b), for the payment of the valid claims of its United States ceding insurers and their assigns and successors in interest. To enable the office to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the office information substantially the same as that required to be reported on the NAIC Annual Statement form by authorized insurers. The assuming insurer shall submit to examination of its books and records by the office and bear the expense of examination.
2.a. Credit for reinsurance must not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:
(I) The insurance regulator of the state in which the trust is domiciled; or
(II) The insurance regulator of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.
b. The form of the trust and any trust amendments must be filed with the insurance regulator of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the insurance regulator.
c. The trust remains in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year, the trustee of the trust shall report to the insurance regulator in writing the balance of the trust and list the trust's investments at the preceding year end, and shall certify that the trust will not expire prior to the following December 31.
3. The following requirements apply to the following categories of assuming insurer:
a. The trust fund for a single assuming insurer consists of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20 million. Not less than 50 percent of the funds in the trust covering the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers and trusteed surplus shall consist of assets of a quality substantially similar to that required in part II of chapter 625. Clean, irrevocable, unconditional, and evergreen letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (5)(a), effective no later than December 31 of the year for which the filing is made and in the possession of the trust on or before the filing date of its annual statement, may be used to fund the remainder of the trust and trusteed surplus.
b.(I) In the case of a group including incorporated and individual unincorporated underwriters:
(A) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after August 1, 1995, the trust consists of a trusteed account in an

amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group;
(B) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of this section, the trust consists of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States; and
(C) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which $100 million must be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.
(II) The incorporated members of the group must not be engaged in any business other than underwriting of a member of the group, and are subject to the same level of regulation and solvency control by the group's domiciliary regulator as the unincorporated members.
(III) Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the insurance regulator an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.
(d) Credit must be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), paragraph (b), or paragraph (c), but only as to the insurance of risks located in jurisdictions in which the reinsurance is required to be purchased by a particular entity by applicable law or regulation of that jurisdiction.
(e) If the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), paragraph (b), paragraph (c), or paragraph (d), the commissioner may allow credit, but only if the assuming insurer holds surplus in excess of $250 million and has a secure financial strength rating from at least two statistical rating organizations deemed acceptable by the commissioner as having experience and expertise in rating insurers doing business in Florida, including, but not limited to, Standard & Poor's, Moody's Investors Service, Fitch Ratings, A.M. Best Company, and Demotech. In determining whether credit should be allowed, the commissioner shall consider the following:
1. The domiciliary regulatory jurisdiction of the assuming insurer.
2. The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and the financial surveillance of the reinsurer.
3. The substance of financial and operating standards for reinsurers in the domiciliary jurisdiction.
4. The form and substance of financial reports required to be filed by the reinsurers in the domiciliary jurisdiction or other public financial statements filed in accordance with generally accepted accounting principles.
5. The domiciliary regulator's willingness to cooperate with United States regulators in general and the office in particular.
6. The history of performance by reinsurers in the domiciliary jurisdiction.
7. Any documented evidence of substantial problems with the enforcement of valid United States judgments in the domiciliary jurisdiction.
8. Any other matters deemed relevant by the commissioner. The commissioner shall give appropriate consideration to insurer group ratings that may have been issued. The commissioner may, in lieu of granting full credit under this subsection, reduce the amount required to be held in trust under paragraph (c).
(f) If the assuming insurer is not authorized or accredited to transact insurance or reinsurance in this state pursuant to paragraph (a) or paragraph (b), the credit permitted by paragraph (c) or paragraph (d) must not be allowed unless the assuming insurer agrees in the reinsurance agreements:
1.a. That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the

ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and
b. To designate the Chief Financial Officer, pursuant to s. 48.151, or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding company.
2. This paragraph is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.
(g) If the assuming insurer does not meet the requirements of paragraph (a) or paragraph (b), the credit permitted by paragraph (c) or paragraph (d) is not allowed unless the assuming insurer agrees in the trust agreements, in substance, to the following conditions:
1. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by paragraph (c), or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the insurance regulator with regulatory oversight over the trust or with an order of a United States court of competent jurisdiction directing the trustee to transfer to the insurance regulator with regulatory oversight all of the assets of the trust fund.
2. The assets must be distributed by and claims must be filed with and valued by the insurance regulator with regulatory oversight in accordance with the laws of the state in which the trust is domiciled which are applicable to the liquidation of domestic insurance companies.
3. If the insurance regulator with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof must be returned by the insurance regulator with regulatory oversight to the trustee for distribution in accordance with the trust agreement.
4. The grantor shall waive any right otherwise available to it under United States law which is inconsistent with this provision.
(4) An asset allowed or a deduction from liability taken for the reinsurance ceded by an insurer to an assuming insurer not meeting the requirements of subsections (2) and (3) is allowed in an amount not exceeding the liabilities carried by the ceding insurer. The deduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer, or, in the case of a trust, held in a qualified United States financial institution, as defined in paragraph (5)(b). This security may be in the form of:
(a) Cash in United States dollars;
(b) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets pursuant to part II of chapter 625;
(c) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (5)(a), effective no later than December 31 of the year for which the filing is made, and in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement; or
(d) Any other form of security acceptable to the office.
(5)(a) For purposes of paragraph (4)(c) regarding letters of credit, a "qualified United States financial institution" means an institution that:

1. Is organized or, in the case of a United States office of a foreign banking organization, is licensed under the laws of the United States or any state thereof;
2. Is regulated, supervised, and examined by United States or state authorities having regulatory authority over banks and trust companies; and
3. Has been determined by either the office or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the office.

(b) For purposes of those provisions of this law which specify institutions that are eligible to act as a fiduciary of a trust, a "qualified United States financial institution" means an institution that is a member of the Federal Reserve System or that has been determined by the office to meet the following criteria:
1. Is organized or, in the case of a United States branch or agency office of a foreign banking organization, is licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and
2. Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(6) For the purposes of this section only, the term "ceding insurer" includes any health maintenance organization operating under a certificate of authority issued under part I of chapter 641.

(7) After notice and an opportunity for a hearing, the office may disallow any credit that it finds would be contrary to the proper interests of the policyholders or stockholders of a ceding domestic insurer.

(8) Credit must be allowed to any ceding insurer for reinsurance otherwise complying with this section only when the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer. Such credit must be allowed to the ceding insurer for reinsurance otherwise complying with this section only when the reinsurance agreement provides that payments by the assuming insurer will be made directly to the ceding insurer or its receiver, except when:

(a) The reinsurance contract specifically provides payment to the named insured, assignee, or named beneficiary of the policy issued by the ceding insurer in the event of the insolvency of the ceding insurer; or

(b) The assuming insurer, with the consent of the named insured, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer in substitution for the obligations of the ceding insurer to the named insured.

(9) No person, other than the ceding insurer, has any rights against the reinsurer which are not specifically set forth in the contract of reinsurance or in a specific written, signed agreement between the reinsurer and the person.

(10) An authorized insurer may not knowingly accept as assuming reinsurer any risk covering subject of insurance which is resident, located, or to be performed in this state and which is written directly by any insurer not then authorized to transact such insurance in this state, other than as to surplus lines insurance lawfully written under part VIII of chapter 626.

(11)(a) Any domestic or commercially domiciled insurer ceding directly written risks of loss under this section shall, within 30 days after receipt of a cover note or similar confirmation of coverage, or, without exception, no later than 6 months after the effective date of the reinsurance treaty, file with the office one copy of a summary statement containing the following information about each treaty:
1. The contract period;
2. The nature of the reinsured's business;
3. An indication as to whether the treaty is proportional, nonproportional, coinsurance, modified coinsurance, or indemnity, as applicable;

4. The ceding company's loss retention per risk;
5. The reinsured limits;
6. Any special contract restrictions;
7. A schedule of reinsurers assuming the risks of loss;
8. An indication as to whether payments to the assuming insurer are based on written premiums or earned premiums;
9. Identification of any intermediary or broker used in obtaining the reinsurance and the commission paid to such intermediary or broker if known; and
10. Ceding commissions and allowances.

(b) The summary statement must be signed and attested to by either the chief executive officer or the chief financial officer of the reporting insurer. In addition to the summary statement, the office may require the filing of any supporting information relating to the ceding of such risks as it deems necessary. If the summary statement prepared by the ceding insurer discloses that the net effect of a reinsurance treaty or treaties (or series of treaties with one or more affiliated reinsurers entered into for the purpose of avoiding the following threshold amount) at any time results in an increase of more than 25 percent to the insurer's surplus as to policyholders, then the insurer shall certify in writing to the office that the relevant reinsurance treaty or treaties comply with the accounting requirements contained in any rule adopted by the commission under subsection (14). If such certificate is filed after the summary statement of such reinsurance treaty or treaties, the insurer shall refile the summary statement with the certificate. In any event, the certificate must state that a copy of the certificate was sent to the reinsurer under the reinsurance treaty.

(c) This subsection applies to cessions of directly written risk or loss. This subsection does not apply to contracts of facultative reinsurance or to any ceding insurer that has a surplus as to policyholders which exceeds $100 million as of the immediately preceding December 31. A ceding insurer otherwise subject to this section which had less than $500,000 in direct premiums written in this state during the preceding calendar year and no more than $250,000 in direct premiums written in this state during the preceding calendar quarter, and which had fewer than 1,000 policyholders at the end of the preceding calendar year, is exempt from this subsection.

(d) An authorized insurer not otherwise exempt from the provisions of this subsection shall provide the information required by this subsection with underlying and supporting documentation upon written request of the office.

(e) The office may, upon a showing of good cause, waive the requirements of this subsection.

(12) If the office finds that a reinsurance agreement creates a substantial risk of insolvency to either insurer entering into the reinsurance agreement, the office may by order require a cancellation of the reinsurance agreement.

(13) No credit shall be allowed for reinsurance with regard to which the reinsurance agreement does not create a meaningful transfer of risk of loss to the reinsurer.

(14) The commission may adopt rules implementing the provisions of this section. Rules are authorized to protect the interests of insureds, claimants, ceding insurers, assuming insurers, and the public. These rules shall be in substantial compliance with:

(a) The National Association of Insurance Commissioners model regulations relating to credit for reinsurance;

(b) The National Association of Insurance Commissioners Accounting Practices and Procedures Manual as of March 2002 and subsequent amendments thereto if the methodology remains substantially consistent; and

(c) The National Association of Insurance Commissioners model regulation for Credit for Reinsurance and Life and Health Reinsurance Agreements.

The commission may further adopt rules to provide for transition from existing requirements for the approval of reinsurers to the accreditation of reinsurers pursuant to this section.

(15) Any reinsurer approved pursuant to s. 624.610(3)(a)2., as such provision existed prior to July 1, 2000, which fails to obtain accreditation pursuant to this section prior to December 30, 2003, shall have its approval terminated by operation of law on that date.
(16) This act shall apply to all cessions on or after January 1, 2001, under reinsurance agreements that have an inception, anniversary, or renewal date on or after January 1, 2001.
624.307 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: November 10, 2014

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

THROUGH: Belinda Miller, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for December 9, 2014
Request for Approval to Publish Amendments to
Rule 69O-137.001 Annual and Quarterly Reporting Requirements
Assignment # 154125-14

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before December 3, 2014 and to the Financial Services Commission on December 9, 2014, with a request to approve for publication the proposed rules.

These rules are being amended to adopt the 2015 NAIC Quarterly Statement Manuals, the 2014 NAIC Annual Statement Instructions Manuals, and the 2014 and 2015 NAIC Accounting Practices and Procedures Manuals. The current rule adopted the 2013 NAIC Quarterly Statement Manuals, the 2012 NAIC Annual Statement Instructions Manuals, and the 2012 and 2013 NAIC Accounting Practices and Procedures Manuals. The rule is also being updated to reflect the current process for filing the annual and quarterly statements as well as to specify that annual and quarterly statements are to be filed electronically and not in any other format.

Sections 624.308(1), 624.424(1), 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-137.001 Annual and Quarterly Reporting Requirements.

(1) The purpose of this rule is to establish uniform requirements for ~~manual and automated~~ reporting of annual and quarterly statement information for all authorized insurers as defined in Section 624.09, F.S.

(2) Each authorized insurer shall file with the Office a full and true statement of its financial condition, transactions, and affairs.

(a) 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 calendar days after each such date.

(b) The Office shall grant an extension of time for filing an annual or quarterly statement if there exist conditions beyond the control of the authorized insurer, such as rehabilitation pursuant to Chapter 631, F.S., or the laws of the state of domicile; severe damage to the insurer's physical premises by a natural or man-made disaster; or some other reason of similar gravity and severity. The extension shall be for the amount of time reasonable to file under the conditions which justified the extension.

(c) For purposes of this rule, the requirement that statements be filed with the Office means that the statement has been transmitted electronically to the National Association of Insurance Commissioners and that the executed Jurat page of said statement has been transmitted electronically to the Office via the Regulatory Electronic Filing System, "REFS" ~~shall be physically on the premises of the Office's headquarters in the Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0300, on or before 5:00 p.m. on the applicable date specified in this subsection~~. The date ~~stamp~~ affixed by the Office's electronic data processing system ~~to the face page of the statement~~ shall serve as evidence of the timeliness of the statement. Annual and

quarterly statements in any other format shall not be submitted to the Office.

~~(d) No information will be accepted through facsimile transmission.~~

(3) Annual and Quarterly Statement ~~Manual and Automated~~ Reporting.

~~(a) Annual and quarterly statements in manual form shall be identical to those filed in accordance with paragraph (b) below, and shall be filed with the Office in accordance with subsection (2), above.~~

(a~~b~~)~~1.~~ Each insurer shall submit its annual and quarterly statement information electronically to the National Association of Insurance Commissioners in accordance with the electronic filing instructions ~~in computer readable format using the diskette medium or other computer readable format compatible with the electronic data processing system~~ specified in paragraph (b~~c~~) below.

~~2. Diskettes or information in a computer readable format shall not be submitted to the Office.~~

~~3. Annual and quarterly statements in diskette form or other computer readable format shall be sent or transmitted electronically to the National Association of Insurance Commissioners, 120 West 12th Street, Suite 1100, Kansas City, Missouri 64105. The envelope shall be marked to indicate that diskettes are enclosed if that medium is used.~~

(b~~c~~)1. The National Association of Insurance Commissioners ~~Annual Statement Diskette Filing Specifications or~~ electronic transmission filing instructions ~~specifications~~ are hereby adopted and incorporated by reference.

2. A copy of these specifications may be obtained from the National Association of Insurance Commissioners at http://www.naic.org/industry_financial_filing.htm.~~, at the address in paragraph (b), above~~.

~~3. These specifications may be inspected during regular business hours at the Office of Insurance Regulation, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0300.~~

(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, 2014 ~~2012~~;

2. The NAIC's Annual Statement Instructions, Life, Accident and Health, 2014 ~~2012~~;

3. The NAIC's Annual Statement Instructions, Health, 2014 ~~2012~~;

4. The NAIC's Annual Statement Instructions, Title, 2014 ~~2012~~; and

5. The NAIC's Accounting Practices and Procedures Manual, as of March 2014 ~~2012~~.

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

1. The NAIC's Quarterly Statement Instructions, Property and Casualty, 2015 ~~2013~~;

2. The NAIC's Quarterly Statement Instructions, Life, Accident and Health 2015 ~~2013~~;

3. The NAIC's Quarterly Statement Instructions, Health 2015 ~~2013~~;

4. The NAIC's Quarterly Statement Instructions, Title 2015 ~~2013~~; and

5. The NAIC's Accounting Practices and Procedures Manual, as of March 2015 ~~2013~~.

(c) Copies of the manuals are available:

1. From the National Association of Insurance Commissioners at http://www.naic.org ~~, 2301 McGee, Suite 800, Kansas City, MO 64108-2604~~, and

2. For inspection during regular business hours at the Office of Insurance Regulation, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0300 ~~at the Office at its headquarters in Tallahassee, Florida, during regular business hours~~.

Rulemaking Authority 624.308(1), 624.424(1) FS. Law Implemented 624.424(1) FS. History–New 3-31-92, Amended 8-24-93, 4-9-95, 4-9-97, 4-4-99, 11-30-99, 2-11-01, 4-5-01, 12-4-01, 12-25-01, 8-

18-02, 7-27-03, Formerly 4-137.001, Amended 1-6-05, 9-15-05, 1-25-07, 3-16-08, 3-4-09, 1-4-10, 9-28-11, 1-28-13, 9-15-13,_____.

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.

M E M O R A N D U M

DATE: November 10, 2014

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

THROUGH: Belinda Miller, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for December 9, 2014
Request for Approval to Publish Amendments to
Rule 69O-138.001; NAIC Financial Condition Handbook Adopted
Assignment # 154139-14

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before December 3, 2014 and to the Financial Services Commission on December 9, 2014, with a request to approve for publication the proposed rules.

These rules are being amended to adopt the 2014 and 2015 NAIC Financial Condition Examiners Handbooks. The current rule adopted the 2013 and 2012 versions of these handbooks.

Sections 624.308(1), 624.316(1)(c), 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-138.001 NAIC Financial Condition Examiners Handbook Adopted.

(1)(a) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 2015 ~~2013~~ is hereby adopted and incorporated by reference.

(b) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 2014 ~~2012~~ is hereby adopted and incorporated by reference.

(2) Financial examinations by the Office shall be performed in substantial conformity with the methodology outlined in the Handbook, so long as that methodology is consistent with statutory accounting principles and the Florida Insurance Code.

(3) A copy of the Examiners Handbook may be:

(a) Obtained from the National Association of Insurance Commissioners, 2301 McGee, Suite 800, Kansas City, MO 64108-2604; or

(b) Inspected at the Office at its headquarters in Tallahassee, Florida, during regular business hours.

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

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: November 3, 2014

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

THROUGH: Belinda Miller, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for December 9, 2014
Request for Final Approval to Adopt Amendments to
Rule 69O-148.001 Funding of Preneed Contracts
Assignment # 129912-12

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before December 3, 2014, and to the Financial Services Commission on December 9, 2014, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on October 21, 2014.

The notice of proposed rules was published on May 23, 2014 in Volume 40, No. 101, of the *Register*. The hearing was not requested, therefore, the hearing was not held. No changes were made to the rule.

The Rule addresses requirements for insurance policies which fund preneed contracts. Currently, the rule caps the maximum face amount at $7,500 and the statute caps the maximum face amount at $12,500. The rule as amended will cross reference to the statute which provides for the limit on the maximum face amount.

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.

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

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

Approved for signature:

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.

(1) through (4) no change.

(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 the amount set forth in Section 626.785, Florida Statutes ~~$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) and (c) no change.

(6) no change.

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. Amended _____.

69O-148.001
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.
626.785 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: November 3, 2014

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

THROUGH: Belinda Miller, General Counsel

FROM: Virginia Christy VC
Stephen Fredrickson SF

SUBJECT: Cabinet Agenda for December 9, 2014
Request for Final Approval to Adopt Repeal of
Rule 69O-123 Civil Remedy
Assignment #130000-12

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before December 3, 2014 and to the Financial Services Commission on December 9, 2014, with a request for Final Approval to Adopt the proposed repeal. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on October 21, 2014.

The notice of proposed rules was published on May 23, 2014 in Volume 40, No. 101, of the *Register.* The hearing was not requested, therefore, the hearing was not held. No changes were made to the proposed repeal of the rule.

Rule Chapter 69O-123, Florida Administrative Code, should be repealed because DFS handles these matters and already has a similar rule.

Sections 624.308(1), 624.155, 624.307(1), F.S., provide rulemaking authority and laws implemented for these rules.

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

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

Approved for signature:

Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-123.001 Purpose
69O-123.002 Procedure

69O-123.001 Purpose.

Specific Authority 624.308(1) FS. Law Implemented 624.155, 624.307(1) FS. History–New 4-25-90, Formerly 4-103.001, 4-123.001 Repealed.

69O-123.002 Procedure.

Specific Authority 624.308(1) FS. Law Implemented 624.155 FS. History–New 4-25-90, Formerly 4-103.002, Amended 8-28-00, Formerly 4-123.002 Repealed..

69O-123
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.

624.155 Civil remedy.—
(1) Any person may bring a civil action against an insurer when such person is damaged:
(a) By a violation of any of the following provisions by the insurer:
1. Section 626.9541(1)(i), (o), or (x);
2. Section 626.9551;
3. Section 626.9705;
4. Section 626.9706;
5. Section 626.9707; or
6. Section 627.7283.
(b) By the commission of any of the following acts by the insurer:
1. Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests;
2. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or
3. Except as to liability coverages, failing to promptly settle claims, when the obligation to settle a claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

Notwithstanding the provisions of the above to the contrary, a person pursuing a remedy under this section need not prove that such act was committed or performed with such frequency as to indicate a general business practice.

(2) Any party may bring a civil action against an unauthorized insurer if such party is damaged by a violation of s. 624.401 by the unauthorized insurer.
(3)(a) As a condition precedent to bringing an action under this section, the department and the authorized insurer must have been given 60 days' written notice of the violation. If the department returns a notice for lack of specificity, the 60-day time period shall not begin until a proper notice is filed.
(b) The notice shall be on a form provided by the department and shall state with specificity the following information, and such other information as the department may require:
1. The statutory provision, including the specific language of the statute, which the authorized insurer allegedly violated.
2. The facts and circumstances giving rise to the violation.
3. The name of any individual involved in the violation.
4. Reference to specific policy language that is relevant to the violation, if any. If the person bringing the civil action is a third party claimant, she or he shall not be required to reference the specific policy language if the authorized insurer has not provided a copy of the policy to the third party claimant pursuant to written request.
5. A statement that the notice is given in order to perfect the right to pursue the civil remedy authorized by this section.
(c) Within 20 days of receipt of the notice, the department may return any notice that does not provide the specific information required by this section, and the department shall indicate the specific deficiencies contained in the notice. A determination by the department to return a notice for lack of specificity shall be exempt from the requirements of chapter 120.

(d) No action shall lie if, within 60 days after filing notice, the damages are paid or the circumstances giving rise to the violation are corrected.
(e) The authorized insurer that is the recipient of a notice filed pursuant to this section shall report to the department on the disposition of the alleged violation.
(f) The applicable statute of limitations for an action under this section shall be tolled for a period of 65 days by the mailing of the notice required by this subsection or the mailing of a subsequent notice required by this subsection.
(4) Upon adverse adjudication at trial or upon appeal, the authorized insurer shall be liable for damages, together with court costs and reasonable attorney's fees incurred by the plaintiff.
(5) No punitive damages shall be awarded under this section unless the acts giving rise to the violation occur with such frequency as to indicate a general business practice and these acts are:
(a) Willful, wanton, and malicious;
(b) In reckless disregard for the rights of any insured; or
(c) In reckless disregard for the rights of a beneficiary under a life insurance contract.

Any person who pursues a claim under this subsection shall post in advance the costs of discovery. Such costs shall be awarded to the authorized insurer if no punitive damages are awarded to the plaintiff.

(6) This section shall not be construed to authorize a class action suit against an authorized insurer or a civil action against the commission, the office, or the department or any of their employees, or to create a cause of action when an authorized health insurer refuses to pay a claim for reimbursement on the ground that the charge for a service was unreasonably high or that the service provided was not medically necessary.
(7) In the absence of expressed language to the contrary, this section shall not be construed to authorize a civil action or create a cause of action against an authorized insurer or its employees who, in good faith, release information about an insured or an insurance policy to a law enforcement agency in furtherance of an investigation of a criminal or fraudulent act relating to a motor vehicle theft or a motor vehicle insurance claim.
(8) The civil remedy specified in this section does not preempt any other remedy or cause of action provided for pursuant to any other statute or pursuant to the common law of this state. Any person may obtain a judgment under either the common-law remedy of bad faith or this statutory remedy, but shall not be entitled to a judgment under both remedies. This section shall not be construed to create a common-law cause of action. The damages recoverable pursuant to this section shall include those damages which are a reasonably foreseeable result of a specified violation of this section by the authorized insurer and may include an award or judgment in an amount that exceeds the policy limits.
(9) A surety issuing a payment or performance bond on the construction or maintenance of a building or roadway project is not an insurer for purposes of subsection (1).

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: November 3, 2014

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

THROUGH: Belinda Miller, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for December 9, 2014
Request for Final Approval to Adopt Repeal of
Rule 69O-228 Continuing Education
Assignment # 130001-12

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before December 3, 2014 and to the Financial Services Commission on December 9, 2014, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on October 21, 2014.

The notice of proposed rules was published on May 23, 2014 in Volume 40, No. 101, of the *Register*. The hearing was not requested, therefore, the hearing was not held. No changes have been made to the rule repeal.

Rule Chapter 69O-228 was promulgated to establish requirements and standards for continuing education courses and records for persons: (1) licensed to solicit or sell insurance or act as limited surety or bail bond agents, (2) licensed to adjust workers' compensation claims in this state and (3) authorized to offer or teach related coursework in this state.

Section 626.2816, Florida Statutes, specifically requires the Department of Financial Services to adopt rules relating to continuing education of this type. Towards this end, the Department of Financial Services has promulgated Rule Chapter 69B-228. The Office does not have sufficient statutory authority to enforce the rules contained in Rule Chapter 69O-228 and as a result this rule chapter should be repealed.

Sections 624.308, 648.26, 626.9611, 624.307(1), 626.2815, 626.2816, 626.869(5), 648.305, 648.306, 624.501, F.S., provide rulemaking authority and laws implemented for these rules.

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

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

Approved for signature:

Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-228.010 Purpose.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 626.2815, 626.2816, 626.2816(2), 626.869(5) FS. History–New 8-17-93, Amended 4-29-01, Formerly 4-228.010 Repealed.

69O-228.020 Scope.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 624.501, 626.2815, 626.869(5), 648.385 FS. History–New 8-17-93, Amended 4-29-01, Formerly 4-228.020 Repealed.

69O-228.030 Definitions.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 626.2815, 626.2816(2), (3), 626.869(5), 648.26, 648.386 FS. History–New 8-17-93, Amended 4-11-94, 4-29-01, Formerly 4-228.030 Repealed.

69O-228.040 Course Providers.

Specific Authority 624.308, 648.26 FS. Law Implemented 624.307(1), 624.501(20), 626.2815, 626.869(5), 648.386 FS. History–New 8-17-93, Amended 4-11-94, 2-28-95, 4-29-01, Formerly 4-228.040 Repealed.

69O-228.050 School Officials.

Specific Authority 624.308, 648.26 FS. Law Implemented 624.307(1), 624.501(20)(c), 626.2815, 626.869(5), 648.36 FS. History–New 8-17-93, Amended 4-11-94, 2-28-95, 4-29-01, Formerly 4-228.050 Repealed.

69O-228.060 Instructors and Supervising Instructors.

Specific Authority 624.308, 648.26 FS. Law Implemented 624.307(1), 624.501(20)(c), 626.2815, 626.869(5), 648.386 FS. History–New 8-17-93, Amended 4-11-94, 2-28-95, 4-29-01, Formerly 4-228.060 Repealed.

69O-228.080 Course Approval; Requirements; Guidelines.

Specific Authority 624.308, 648.26 FS. Law Implemented 624.307(1), 624.501(20), 626.2815, 626.869(5), 648.386 FS. History–New 8-17-93, Amended 4-11-94, 2-28-95, 4-29-01, Formerly 4-228.080 Repealed.

69O-228.090 Course Offerings and Attendance Records.

Specific Authority 624.308, 648.26 FS. Law Implemented 624.307(1), 626.2815, 626.869(5), 648.386 FS. History–New 8-17-93, Amended 4-11-94, 4-29-01, Formerly 4-228.090 Repealed.

69O-228.100 Certification of Students.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 624.501(20)(c), 626.2815, 626.869(5) FS. History–New 8-17-93, Amended 4-11-94, 4-29-01, Formerly 4-228.100 Repealed.

69O-228.110 Textbooks.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 626.2815, 626.869(5) FS. History–New 8-17-93, Amended 4-29-01, Formerly 4-228.110 Repealed.

69O-228.120 Course Fees.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 626.2815, 626.869(5) FS. History–New 8-17-93, Amended 4-29-01, Formerly 4-228.120 Repealed.

69O-228.130 Facilities.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 626.2815, 626.869(5) FS. History–New 8-17-93, Amended 4-29-01, Formerly 4-228.130 Repealed.

69O-228.150 Advertising.

Specific Authority 624.308, 626.9611 FS. Law Implemented 624.307(1), 626.2815, 626.869(5), 626.9541(1)(b) FS. History–New 8-17-93, Amended 4-29-01, Formerly 4-228.150 Repealed.

69O-228.160 Prohibited Practices.

Specific Authority 624.308, 648.26 FS. Law Implemented 624.307(1), 626.2815, 626.869(5), 648.386 FS. History–New 8-17-93, Amended 4-29-01, Formerly 4-228.160 Repealed.

69O-228.180 Forms.

Specific Authority 624.308, 648.26 FS. Law Implemented 624.307(1), 624.501, 626.2815, 626.8419(1), 626.869(5), 627.952(1)(b), 648.386 FS. History–New 8-17-93, Amended 4-29-01, Formerly 4-228.180 Repealed.

69O-228.190 Transition Time in the Event of Rule Changes.

Specific Authority 624.308, 648.26 FS. Law Implemented 624.307(1), 624.501, 626.2815, 626.611, 626.621, 626.681, 626.869(5), 648.386 FS. History–New 8-17-93, Amended 4-29-01, Formerly 4-228.190 Repealed.

69O-228.210 Penalties for Course Providers, School Officials, Supervising Instructors, Instructors, and Monitors.

Specific Authority 624.308, 648.26 FS. Law Implemented 624.307(1), 624.4211, 626.2815, 626.611, 626.621, 626.869(5), 648.385, 648.386 FS. History–New 8-17-93, Amended 4-11-94, 4-29-01, Formerly 4-228.210 Repealed.

69O-228.220 Licensee Compliance; Requirements; Penalties for Non-Compliance.

Specific Authority 624.308, 648.26 FS. Law Implemented 624.307(1), 616.221(2)(d), 626.2815, 626.611, 626.621, 626.681, 626.691, 626.869(5), 648.385 FS. History–New 8-17-93, Amended 4-11-94, 4-29-01, Formerly 4-228.220 Repealed.

69O-228.230 Extensions.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 624.501, 626.2815, 626.869(5) FS. History–New 8-17-93, Amended 4-11-94, 4-29-01, Formerly 4-228.230 Repealed.

69O-228.240 Applicability of Continuing Education Requirement for New Licensees.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 626.2815, 626.869(5) FS. History–New 8-17-93, Amended 4-11-94, 4-29-01, Formerly 4-228.240 Repealed.

69O-228.250 Exempted Licensees.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 626.2815(3)(c), 626.869(5) FS. History–New 8-17-93, Amended 4-29-01, Formerly 4-228.250 Repealed.

69O-228
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.

624.307 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.

648.26 Department of Financial Services; administration.—
(1) The department shall administer the provisions of this chapter as provided in this chapter.
(a) The department has authority to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring powers or duties upon it.
(b) The department may employ and discharge such employees, examiners, counsel, and other assistants as shall be deemed necessary, and it shall prescribe their duties; their compensation shall be the same as other state employees receive for similar services.
(2) The department shall adopt a seal by which its proceedings are authenticated. Any written instrument purporting to be a copy of any action, proceeding, or finding of fact by the department, or any record of the department authenticated by the seal, shall be accepted by all the courts of this state as prima facie evidence of the contents thereof.
(3) The papers, documents, reports, or any other investigatory records of the department are confidential and exempt from the provisions of s. 119.07(1) until such investigation is completed or ceases to be active. For the purpose of this section, an investigation is considered "active" while the investigation is being conducted by the department with a reasonable, good faith belief that it may lead to the filing of administrative, civil, or criminal proceedings. An investigation does not cease to be active if the department is proceeding with reasonable dispatch and there is good faith belief that action may be initiated by the department or other administrative or law enforcement agency.

626.9611 Rules.—
(1) The department or commission may, in accordance with chapter 120, adopt reasonable rules as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by s. 626.9541 or s. 626.9551, but the rules shall not enlarge upon or extend the provisions of ss. 626.9541 and 626.9551.
(2) The department and the commission shall, in accordance with chapter 120, adopt rules to protect members of the United States Armed Forces from dishonest or predatory insurance sales practices by insurers and insurance agents. The rules shall identify specific false, misleading, deceptive, or unfair methods of competition, acts, or practices which are prohibited by s. 626.9541 or s. 626.9551. The rules shall be based upon model rules or model laws adopted by the National Association of Insurance Commissioners which identify certain insurance practices involving the solicitation or sale of insurance and annuities to members of the United States Armed Forces which are false, misleading, deceptive, or unfair.

69O-228
Rulemaking Authority

626.2815 Continuing education requirements.—
(1) The purpose of this section is to establish requirements and standards for continuing education courses for individuals licensed to solicit, sell, or adjust insurance in the state.
(2) Except as otherwise provided in this section, this section applies to individuals licensed to engage in the sale of insurance or adjustment of insurance claims in this state for all lines of insurance for which an examination is required for licensing and to each insurer, employer, or appointing entity, including, but not limited to, those created or existing pursuant to s. 627.351. This section does not apply to an individual who holds a license for the sale of any line of insurance for which an examination is not required by the laws of this state or who holds a limited license as a crop or hail and multiple-peril crop insurance agent. Licensees who are unable to comply with the continuing education requirements due to active duty in the military may submit a written request for a waiver to the department.
[1](3) Each licensee subject to this section must, except as set forth in paragraphs (b), (c), (d), and (f), complete a minimum of 24 hours of continuing education courses every 2 years in basic or higher-level courses prescribed by this section or in other courses approved by the department.
(a) Each licensee must complete 3 hours of continuing education, approved by the department, every 2 years on the subject matter of ethics. Each licensed general lines agent and customer representative must complete 1 hour of continuing education, approved by the department, every 2 years on the subject matter of premium discounts available on property insurance policies based on various hurricane mitigation options and the means for obtaining the discounts.
(b) A licensee who has been licensed for 6 or more years must complete 20 hours of continuing education every 2 years in intermediate or advanced-level courses prescribed by this section or in other courses approved by the department.
(c) A licensee who has been licensed for 25 years or more and is a CLU or a CPCU or has a Bachelor of Science degree in risk management or insurance with evidence of 18 or more semester hours in upper-level insurance-related courses must complete 10 hours of continuing education courses every 2 years in courses prescribed by this section or in other courses approved by the department.
(d) An individual who holds a license as a customer representative, limited customer representative, title agent, motor vehicle physical damage and mechanical breakdown insurance agent, or an industrial fire insurance or burglary insurance agent and who is not a licensed life or health agent, must complete 10 hours of continuing education courses every 2 years.
(e) An individual who holds a license to solicit or sell life or health insurance and a license to solicit or sell property, casualty, surety, or surplus lines insurance must complete courses in life or health insurance for one-half of the total hours required and courses in property, casualty, surety, or surplus lines insurance for one-half of the total hours required. However, a licensee who holds an industrial fire or burglary insurance license and who is a licensed life or health agent must complete 4 hours of continuing education courses every 2 years related to industrial fire or burglary insurance and the remaining number of hours of continuing education courses related to life or health insurance.
(f) An individual subject to chapter 648 must complete a minimum of 14 hours of continuing education courses every 2 years.
(g) Excess hours accumulated during any 2-year compliance period may be carried forward to the next compliance period.
(h) An individual teaching an approved course of instruction or lecturing at any approved seminar and attending the entire course or seminar qualifies for the same number of classroom hours as would be granted to a person taking and successfully completing such course or seminar. Credit is limited to the number of hours actually taught unless a person attends the entire course or seminar. An individual who is an official of or employed by a governmental entity in this state and serves as a professor, instructor, or [2]in another

position or office, the duties and responsibilities of which are determined by the department to require monitoring and review of insurance laws or insurance regulations and practices, is exempt from this section.
(4) Compliance with continuing education requirements is a condition precedent to the issuance, continuation, reinstatement, or renewal of any appointment subject to this section. However:
(a) An appointing entity, except one that appoints individuals who are employees or exclusive independent contractors of the appointing entity, may not require, directly or indirectly, as a condition of such appointment or the continuation of such appointment, the taking of an approved course or program by any appointee or potential appointee which is not of the appointee's choosing.
(b) Any entity created or existing pursuant to s. 627.351 may require employees to take training of any type relevant to their employment but may not require appointees who are not employees to take any approved course or program unless the course or program deals solely with the appointing entity's internal procedures or products or with subjects substantially unique to the appointing entity.
(5) For good cause shown, the department may grant an extension of time during which the requirements of this section may be completed, but such extension may not exceed 1 year.
(6) A nonresident licensee who must complete continuing education requirements in his or her home state may use the home state requirements to also meet this state's continuing education requirements if the licensee's home state recognizes reciprocity with this state's continuing education requirements. A nonresident licensee whose home state does not have a continuing education requirement but is licensed for the same class of business in another state that has a continuing education requirement may comply with this section by furnishing proof of compliance with the other state's requirement if that state has a reciprocal agreement with this state relative to continuing education. A nonresident licensee whose home state does not have such continuing education requirements, and who is not licensed as a nonresident licensee in a state that has continuing education requirements and reciprocates with this state, must meet the continuing education requirements of this state.
[3](7) Any person who holds a license to solicit or sell life insurance in this state must complete a minimum of 3 hours in continuing education, approved by the department, on the subject of suitability in annuity and life insurance transactions. This requirement does not apply to an agent who does not have any active life insurance or annuity contracts. In applying this exemption, the department may require the filing of a certification attesting that the agent has not sold life insurance or annuities during the continuing education compliance cycle in question and does not have any active life insurance or annuity contracts. A licensee may use the hours obtained under this paragraph to satisfy the requirement for continuing education in ethics under paragraph (3)(a).
(8) The following courses may be completed in order to meet the elective continuing education course requirements:
(a) Any part of the Life Underwriter Training Council Life Course Curriculum: 24 hours; Health Course: 12 hours.
(b) Any part of the American College "CLU" diploma curriculum: 24 hours.
(c) Any part of the Insurance Institute of America's program in general insurance: 12 hours.
(d) Any part of the American Institute for Property and Liability Underwriters' Chartered Property Casualty Underwriter (CPCU) professional designation program: 24 hours.
(e) Any part of the Certified Insurance Counselor program: 21 hours.
(f) Any part of the Accredited Advisor in Insurance: 21 hours.
(g) In the case of title agents, completion of the Certified Land Closer (CLC) professional designation program and receipt of the designation: 24 hours.

(h) In the case of title agents, completion of the Certified Land Searcher (CLS) professional designation program and receipt of the designation: 24 hours.
(i) Any insurance-related course that is approved by the department and taught by an accredited college or university per credit hour granted: 12 hours.
(j) Any course, including courses relating to agency management or errors and omissions, developed or sponsored by an authorized insurer or recognized agents' association or insurance trade association or an independent study program of instruction, subject to approval by the department, qualifies for the equivalency of the number of classroom hours assigned by the department. However, unless otherwise provided in this section, continuing education hours may not be credited toward meeting the requirements of this section unless the course is provided by classroom instruction or results in a monitored examination. A monitored examination is not required for:
1. An independent study program of instruction presented through interactive, online technology that the department determines has sufficient internal testing to validate the student's full comprehension of the materials presented; or
2. An independent study program of instruction presented on paper or in printed material which imposes a final closed book examination that meets the requirements of the department's rule for self-study courses. The examination may be taken without a proctor if the student presents to the provider a sworn affidavit certifying that the student did not consult any written materials or receive outside assistance of any kind or from any person, directly or indirectly, while taking the examination. If the student is an employee of an agency or corporate entity, the student's supervisor or a manager or owner of the agency or corporate entity must also sign the sworn affidavit. If the student is self-employed, a sole proprietor, or a partner, or if the examination is administered online, the sworn affidavit must also be signed by a disinterested third party. The sworn affidavit must be received by the approved provider before reporting continuing education credits to the department.
(9) Each person or entity sponsoring a course for continuing education credit must furnish, within 21 days after completion of the course, in a form satisfactory to the department or its designee, a roster showing the name and license number of all persons successfully completing such course and requesting credit.
(10) The department may immediately terminate or refuse to renew the appointment of an agent or adjuster who has been notified by the department that his or her continuing education requirements have not been certified, unless the agent or adjuster has been granted an extension or waiver by the department. The department may not issue a new appointment of the same or similar type to a licensee who was denied a renewal appointment for failing to complete continuing education as required until the licensee completes his or her continuing education requirement.
(11) The department may contract services relative to the administration of the continuing education program to a private entity. The contract shall be procured as a contractual service pursuant to s. 287.057.

626.2816 Regulation of continuing education for licensees, course providers, instructors, school officials, and monitor groups.—
(1) Continuing education course providers, instructors, school officials, and monitor groups must be approved by the department before offering continuing education courses pursuant to s. 626.2815 or s. 626.869.
(2) The department shall adopt rules establishing standards for the approval, regulation, and operation of the continuing education programs and for the discipline of licensees, course providers, instructors, school officials, and monitor groups. The standards must be designed to ensure that such course providers, instructors, school officials, and monitor groups have the knowledge, competence, and integrity to fulfill the educational objectives of ss. 626.2815, 626.869, 648.385, and 648.386.

(3) The department shall adopt rules establishing a process by which compliance with the continuing education requirements of ss. 626.2815, 626.869, 648.385, and 648.386 can be determined, the establishment of a continuing education compliance period for licensees, and forms necessary to implement such a process.

626.869 License, adjusters; continuing education.—

(5) The regulation of continuing education for licensees, course providers, instructors, school officials, and monitor groups shall be as provided in s. 626.2816.

624.501 Filing, license, appointment, and miscellaneous fees.—The department, commission, or office, as appropriate, shall collect in advance, and persons so served shall pay to it in advance, fees, licenses, and miscellaneous charges as follows:
(1) Certificate of authority of insurer.
(a) Filing application for original certificate of authority or modification thereof as a result of a merger, acquisition, or change of controlling interest due to a sale or exchange of stock, including all documents required to be filed therewith, filing fee.....$1,500.00
(b) Reinstatement fee.....$50.00
(2) Charter documents of insurer.
(a) Filing articles of incorporation or other charter documents, other than at time of application for original certificate of authority, filing fee.....$10.00
(b) Filing amendment to articles of incorporation or charter, other than at time of application for original certificate of authority, filing fee.....$5.00
(c) Filing bylaws, when required, or amendments thereof, filing fee.....$5.00
(3) Annual license tax of insurer, each domestic insurer, foreign insurer, and alien insurer (except that, as to fraternal benefit societies insuring less than 200 members in this state and the members of which as a prerequisite to membership possess a physical handicap or disability, such license tax shall
be $25).....$1,000.00
(4) Statements of insurer, filing (except when filed as part of application for original certificate of authority), filing fees:
(a) Annual statement.....$250.00
(b) Quarterly statement.....$250.00
(5) All insurance representatives, application for license, application for reinstatement of suspended license, each filing, filing fee.....$50.00
(6) Insurance representatives, property, marine, casualty, and surety insurance.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Customer representative's original appointment and biennial renewal or continuation thereof:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(c) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer.....$60.00
(d) Service representatives; managing general agents.

Original appointment and biennial renewal or continuation thereof, each insurer or managing general agent, whichever is applicable.....$60.00

(7) Life insurance agents.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer or agent making an appointment:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer.....$60.00
(8) Health insurance agents.
(a) Agent's original appointment and biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Nonresident agent's original appointment and biennial renewal or continuation thereof, appointment fee, each insurer.....$60.00
(9)(a) Except as provided in paragraph (b), all limited appointments as agent, as provided for in s. 626.321. Agent's original appointment and biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) For all limited appointments as agent, as provided in s. 626.321(1)(c) and (d), the agent's original appointment and biennial renewal or continuation thereof for each insurer is equal to the number of offices, branch offices, or places of business covered by the license multiplied by the fees set forth in paragraph (a).
(10) Fraternal benefit society agents. Original appointment and biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(11) Surplus lines agent. Agent's appointment and biennial renewal or continuation thereof, appointment fee.....$150.00
(12) Adjusters:
(a) Adjuster's original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(b) Nonresident adjuster's original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(c) Emergency adjuster's license, appointment fee.....$10.00
(d) Fee to cover actual cost of credit report, when such report must be secured by department.
(13) Examination—Fee to cover actual cost of examination.
(14) Temporary license and appointment as agent or adjuster, where expressly provided for, rate of fee for each month of the period for which the license and appointment is issued.....$5.00
(15) Issuance, reissuance, reinstatement, modification resulting in a modified license being issued, duplicate copy of any insurance representative license, or an appointment being reinstated.....$5.00
(16) Additional appointment continuation fees as prescribed in chapter 626.....$5.00
(17) Filing application for permit to form insurer as referred to in chapter 628, filing fee.....$25.00
(18) Annual license fee of rating organization, each domestic or foreign organization.....$25.00
(19) Miscellaneous services:
(a) For copies of documents or records on file with the department, commission, or office, per
page.....$ .15
(b) For each certificate of the department, commission, or office under its seal, authenticating any document or other instrument (other than a license or certificate of authority).....$5.00
(c) For preparing lists of agents, adjusters, and other insurance representatives, and for other miscellaneous services, such reasonable charge as may be fixed by the office or department.

(d) For processing requests for approval of continuing education courses, processing fee.....$100.00
(e) Insurer's registration fee for agent exchanging business more than 24 times in calendar year under s. 626.752, s. 626.793, or s. 626.837, registration fee per agent per year.....$30.00
(20) Adjusting firm, original or renewal 3-year license.....$60.00
(21) Limited surety agent or professional bail bond agent, as defined in s. 648.25, each agent and each insurer represented. Original appointment and biennial renewal or continuation thereof, each agent or insurer, whichever is applicable:

Appointment fee.....$44.00

State tax.....24.00

County tax.....12.00

Total.....$80.00

(22) Certain military installations, as authorized under s. 626.322: original appointment and biennial renewal or continuation thereof, each insurer.....$20.00
(23) Filing application for original certificate of authority for third-party administrator or original certificate of approval for a service company, including all documents required to be filed therewith, filing fee.....$100.00
(24) Fingerprinting processing fee—Fee to cover fingerprint processing.
(25) Sales representatives, miscellaneous lines. Original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(26) Reinsurance intermediary:
(a) Application filing and license fee.....$50.00
(b) Original appointment and biennial renewal or continuation thereof, appointment fee.....$60.00
(27) Title insurance agents:
(a) Agent's original appointment or biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(b) Agency original appointment or biennial renewal or continuation thereof, each insurer:

Appointment fee.....$42.00

State tax.....12.00

County tax.....6.00

Total.....$60.00

(c) Filing for title insurance agent's license:

Application for filing, each filing, filing fee.....$10.00

(d) Additional appointment continuation fee as prescribed by s. 626.843.....$5.00
(e) Title insurer and title insurance agency administrative surcharge:
1. On or before January 30 of each calendar year, each title insurer shall pay to the office for each licensed title insurance agency appointed by the title insurer and for each retail office of the insurer on January 1 of that calendar year an administrative surcharge of $200.00.
2. On or before January 30 of each calendar year, each licensed title insurance agency shall remit to the department an administrative surcharge of $200.00.

The administrative surcharge may be used solely to defray the costs to the department and office in their examination or audit of title insurance agencies and retail offices of title insurers and to gather title insurance data for statistical purposes to be furnished to and used by the office in its regulation of title insurance.

(28) Late filing of appointment renewals for agents, adjusters, and other insurance representatives, each appointment.....$20.00

648.385 Continuing education required; requirements.—
(1) The purpose of this section is to establish requirements and standards for continuing education courses for persons authorized to write bail bonds in this state.
(2) Each person subject to this chapter must complete a minimum of 14 hours of continuing education courses every 2 years as specified in s. 626.2815.

648.26 Department of Financial Services; administration.—
(1) The department shall administer the provisions of this chapter as provided in this chapter.
(a) The department has authority to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring powers or duties upon it.
(b) The department may employ and discharge such employees, examiners, counsel, and other assistants as shall be deemed necessary, and it shall prescribe their duties; their compensation shall be the same as other state employees receive for similar services.
(2) The department shall adopt a seal by which its proceedings are authenticated. Any written instrument purporting to be a copy of any action, proceeding, or finding of fact by the department, or any record of the department authenticated by the seal, shall be accepted by all the courts of this state as prima facie evidence of the contents thereof.
(3) The papers, documents, reports, or any other investigatory records of the department are confidential and exempt from the provisions of s. 119.07(1) until such investigation is completed or ceases to be active. For the purpose of this section, an investigation is considered "active" while the investigation is being conducted by the department with a reasonable, good faith belief that it may lead to the filing of administrative, civil, or criminal proceedings. An investigation does not cease to be active if the department is proceeding with reasonable dispatch and there is good faith belief that action may be initiated by the department or other administrative or law enforcement agency.

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Rulemaking Authority

648.386 Qualifications for prelicensing and continuing education schools and instructors.—
(1) SCHOOLS AND CURRICULUM FOR PRELICENSING SCHOOLS.—In order to be considered for approval and certification as an approved limited surety agent and professional bail bond agent prelicensing school, such entity must:
(a)1. Offer a minimum of two 120-hour classroom-instruction basic certification courses in the criminal justice system per calendar year unless a reduced number of course offerings per calendar year is warranted in accordance with rules promulgated by the department; or
2. Offer a department-approved correspondence course pursuant to department rules.
(b) Submit a prelicensing course curriculum to the department for approval.
(c) If applicable, offer prelicensing classes which are taught by instructors approved by the department.
(2) SCHOOLS AND CURRICULUM FOR CONTINUING EDUCATION SCHOOLS.—In order to be considered for approval and certification as an approved limited surety agent and professional bail bond agent continuing education school, such entity must:
(a) Provide a minimum of three continuing education classes per calendar year.
(b) Submit a course curriculum to the department for approval.
(c) Offer continuing education classes which are comprised of a minimum of 2 hours of approved coursework and are taught by an approved supervising instructor or guest lecturer approved by the entity or the supervising instructor.
(3) GEOGRAPHIC REQUIREMENTS.—Any provider approved under this section by the department to offer prelicensing courses or continuing education courses shall be required to offer such courses in at least two geographic areas of the state until such time that the department determines that there are adequate providers statewide to provide these courses to applicants and licensees.
(4) INSTRUCTOR'S DUTIES AND QUALIFICATIONS.—
(a) Each course must have a supervising instructor who is approved by the department. The supervising instructor shall be present at all classes. The supervising instructor is responsible for:
1. All course instructors.
2. All guest lecturers.
3. The course outlines and curriculum.
4. Certification of each attending limited surety agent or professional bail bond agent.
5. Completion of all required forms.
6. Assuring that the course is approved.

Either the entity or the supervising instructor may approve guest lecturers.

(b) In order to obtain department approval as a supervising instructor, the following qualifications must be met:
1. During the past 15 years, the person must have had at least 10 years' experience as a manager or officer of a managing general agent in this state as prescribed in s. 648.388;
2. During the past 15 years, the person must have had at least 10 years' experience as a manager or officer of an insurance company authorized to and actively engaged in underwriting bail in this state, provided there is a showing that the manager's or officer's experience is directly related to the bail bond industry; or
3. The person has been a licensed bail bond agent in this state for at least 10 years.
(c) In order to obtain department approval as an instructor or guest lecturer, the person must be qualified by education or experience in the specific area of instruction as prescribed by department rules.
(d) A person teaching any approved course of instruction or lecturing at any approved seminar and attending the entire course or seminar shall qualify for the same number of classroom hours as would be granted to a person taking and successfully completing such

course, seminar, or program. Credit shall be limited to the number of hours actually taught unless a person attends the entire course or seminar.
(e) The department shall adopt rules necessary to carry out the duties conferred upon it under this section.

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:
(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.

626.8419 Appointment of title insurance agency.—
(1) The title insurer engaging or employing the title insurance agency must file with the department, on forms furnished by the department, an application certifying that the proposed title insurance agency meets all of the following requirements:
(a) The agency must have obtained a fidelity bond in an amount, not less than $50,000, acceptable to the insurer appointing the agency. If a fidelity bond is unavailable generally, the department must adopt rules for alternative methods to comply with this paragraph.
(b) The agency must have obtained errors and omissions insurance in an amount acceptable to the insurer appointing the agency. The amount of the coverage may not be less than $250,000 per claim and an aggregate limit with a deductible no greater than $10,000. If errors and omissions insurance is unavailable generally, the department must adopt rules for alternative methods to comply with this paragraph.
(c) Notwithstanding s. 626.8418(2), the agency must have obtained a surety bond in an amount not less than $35,000 made payable to the title insurer or title insurers appointing the agency. The surety bond must be for the benefit of any appointing title insurer damaged by a violation by the title insurance agency of its contract with the appointing title insurer. If the surety bond is payable to multiple title insurers, the surety bond must provide that each title insurer is to be notified in the event a claim is made upon the surety bond or the bond is terminated.
(d) The surety bond must remain in effect and unimpaired as long as the agency is appointed by a title insurer. The agency must provide written proof to the appointing title insurer or insurers on an annual basis evidencing that the surety bond is still in effect and unimpaired.
(e) A title insurer may not provide the surety bond directly or indirectly on behalf of the agency.

627.952 Risk retention and purchasing group agents.—
(1) Any person offering, soliciting, selling, purchasing, administering, or otherwise servicing insurance contracts, certificates, or agreements for any purchasing group or risk retention group to any resident of this state, either directly or indirectly, by the use of mail,

advertising, or other means of communication, shall obtain a license and appointment to act as a resident general lines agent, if a resident of this state, or a nonresident general lines agent if not a resident. Any such person shall be subject to all requirements of the Florida Insurance Code.
(b) Any person required to be licensed and appointed under this subsection, in order to place business through Florida eligible surplus lines carriers, must, if a resident of this state, be licensed and appointed as a surplus lines agent. If not a resident of this state, such person must be licensed and appointed as a surplus lines agent in her or his state of residence and file and maintain a fidelity bond in favor of the people of the State of Florida executed by a surety company admitted in this state and payable to the State of Florida; however, such nonresident is limited to the provision of insurance for purchasing groups. The bond must be continuous in form and in the amount of not less than $50,000, aggregate liability. The bond must remain in force and effect until the surety is released from liability by the department or until the bond is canceled by the surety. The surety may cancel the bond and be released from further liability upon 30 days' prior written notice to the department. The cancellation does not affect any liability incurred or accrued before the termination of the 30-day period. Upon receipt of a notice of cancellation, the department shall immediately notify the agent.

626.611 Grounds for compulsory refusal, suspension, or revocation of agent's, title agency's, adjuster's, customer representative's, service representative's, or managing general agent's license or appointment.—The department shall deny an application for, suspend, revoke, or refuse to renew or continue the license or appointment of any applicant, agent, title agency, adjuster, customer representative, service representative, or managing general agent, and it shall suspend or revoke the eligibility to hold a license or appointment of any such person, if it finds that as to the applicant, licensee, or appointee any one or more of the following applicable grounds exist:
(1) Lack of one or more of the qualifications for the license or appointment as specified in this code.
(2) Material misstatement, misrepresentation, or fraud in obtaining the license or appointment or in attempting to obtain the license or appointment.
(3) Failure to pass to the satisfaction of the department any examination required under this code.
(4) If the license or appointment is willfully used, or to be used, to circumvent any of the requirements or prohibitions of this code.
(5) Willful misrepresentation of any insurance policy or annuity contract or willful deception with regard to any such policy or contract, done either in person or by any form of dissemination of information or advertising.
(6) If, as an adjuster, or agent licensed and appointed to adjust claims under this code, he or she has materially misrepresented to an insured or other interested party the terms and coverage of an insurance contract with intent and for the purpose of effecting settlement of claim for loss or damage or benefit under such contract on less favorable terms than those provided in and contemplated by the contract.
(7) Demonstrated lack of fitness or trustworthiness to engage in the business of insurance.
(8) Demonstrated lack of reasonably adequate knowledge and technical competence to engage in the transactions authorized by the license or appointment.
(9) Fraudulent or dishonest practices in the conduct of business under the license or appointment.
(10) Misappropriation, conversion, or unlawful withholding of moneys belonging to insurers or insureds or beneficiaries or to others and received in conduct of business under the license or appointment.

(11) Unlawfully rebating, attempting to unlawfully rebate, or unlawfully dividing or offering to divide his or her commission with another.
(12) Having obtained or attempted to obtain, or having used or using, a license or appointment as agent or customer representative for the purpose of soliciting or handling "controlled business" as defined in s. 626.730 with respect to general lines agents, s. 626.784 with respect to life agents, and s. 626.830 with respect to health agents.
(13) Willful failure to comply with, or willful violation of, any proper order or rule of the department or willful violation of any provision of this code.
(14) Having been found guilty of or having pleaded guilty or nolo contendere to a felony or a crime punishable by imprisonment of 1 year or more under the law of the United States of America or of any state thereof or under the law of any other country which involves moral turpitude, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases.
(15) Fraudulent or dishonest practice in submitting or aiding or abetting any person in the submission of an application for workers' compensation coverage under chapter 440 containing false or misleading information as to employee payroll or classification for the purpose of avoiding or reducing the amount of premium due for such coverage.
(16) Sale of an unregistered security that was required to be registered, pursuant to chapter 517.
(17) In transactions related to viatical settlement contracts as defined in s. 626.9911:
(a) Commission of a fraudulent or dishonest act.
(b) No longer meeting the requirements for initial licensure.
(c) Having received a fee, commission, or other valuable consideration for his or her services with respect to viatical settlements that involved unlicensed viatical settlement providers or persons who offered or attempted to negotiate on behalf of another person a viatical settlement contract as defined in s. 626.9911 and who were not licensed life agents.
(d) Dealing in bad faith with viators.
626.621 Grounds for discretionary refusal, suspension, or revocation of agent's, adjuster's, customer representative's, service representative's, or managing general agent's license or appointment.—The department may, in its discretion, deny an application for, suspend, revoke, or refuse to renew or continue the license or appointment of any applicant, agent, adjuster, customer representative, service representative, or managing general agent, and it may suspend or revoke the eligibility to hold a license or appointment of any such person, if it finds that as to the applicant, licensee, or appointee any one or more of the following applicable grounds exist under circumstances for which such denial, suspension, revocation, or refusal is not mandatory under s. 626.611:
(1) Any cause for which issuance of the license or appointment could have been refused had it then existed and been known to the department.
(2) Violation of any provision of this code or of any other law applicable to the business of insurance in the course of dealing under the license or appointment.
(3) Violation of any lawful order or rule of the department, commission, or office.
(4) Failure or refusal, upon demand, to pay over to any insurer he or she represents or has represented any money coming into his or her hands belonging to the insurer.
(5) Violation of the provision against twisting, as defined in s. 626.9541(1)(l).
(6) In the conduct of business under the license or appointment, engaging in unfair methods of competition or in unfair or deceptive acts or practices, as prohibited under part IX of this chapter, or having otherwise shown himself or herself to be a source of injury or loss to the public.
(7) Willful overinsurance of any property or health insurance risk.
(8) Having been found guilty of or having pleaded guilty or nolo contendere to a felony or a crime punishable by imprisonment of 1 year or more under the law of the United States of America or of any state thereof or under the law of any other country, without regard to

whether a judgment of conviction has been entered by the court having jurisdiction of such cases.
(9) If a life agent, violation of the code of ethics.
(10) Cheating on an examination required for licensure or violating test center or examination procedures published orally, in writing, or electronically at the test site by authorized representatives of the examination program administrator. Communication of test center and examination procedures must be clearly established and documented.
(11) Failure to inform the department in writing within 30 days after pleading guilty or nolo contendere to, or being convicted or found guilty of, any felony or a crime punishable by imprisonment of 1 year or more under the law of the United States or of any state thereof, or under the law of any other country without regard to whether a judgment of conviction has been entered by the court having jurisdiction of the case.
(12) Knowingly aiding, assisting, procuring, advising, or abetting any person in the violation of or to violate a provision of the insurance code or any order or rule of the department, commission, or office.
(13) Has been the subject of or has had a license, permit, appointment, registration, or other authority to conduct business subject to any decision, finding, injunction, suspension, prohibition, revocation, denial, judgment, final agency action, or administrative order by any court of competent jurisdiction, administrative law proceeding, state agency, federal agency, national securities, commodities, or option exchange, or national securities, commodities, or option association involving a violation of any federal or state securities or commodities law or any rule or regulation adopted thereunder, or a violation of any rule or regulation of any national securities, commodities, or options exchange or national securities, commodities, or options association.
(14) Failure to comply with any civil, criminal, or administrative action taken by the child support enforcement program under Title IV-D of the Social Security Act, 42 U.S.C. ss. 651 et seq., to determine paternity or to establish, modify, enforce, or collect support.

626.681 Administrative fine in lieu of or in addition to suspension, revocation, or refusal of license, appointment, or disapproval.—
(1) Except as to insurance agencies, if the department finds that one or more grounds exist for the suspension, revocation, or refusal to issue, renew, or continue any license or appointment issued under this chapter, or disapproval of a continuing education course provider, instructor, school official, or monitor groups, the department may, in its discretion, in lieu of or in addition to such suspension or revocation, or in lieu of such refusal, or disapproval, and except on a second offense or when such suspension, revocation, or refusal is mandatory, impose upon the licensee, appointee, course provider, instructor, school official, or monitor group an administrative penalty in an amount up to $500 or, if the department has found willful misconduct or willful violation on the part of the licensee, appointee, course provider, instructor, school official, or monitor group up to $3,500. The administrative penalty may, in the discretion of the department, be augmented by an amount equal to any commissions received by or accruing to the credit of the licensee or appointee in connection with any transaction as to which the grounds for suspension, revocation, or refusal related.
(2) With respect to insurance agencies, if the department finds that one or more grounds exist for the suspension, revocation, or refusal to issue, renew, or continue any license issued under this chapter, the department may, in its discretion, in lieu of or in addition to such suspension or revocation, or in lieu of such refusal, impose upon the licensee an administrative penalty in an amount not to exceed $10,000 per violation. The administrative penalty may, in the discretion of the department, be augmented by an amount equal to any commissions received by or accruing to the credit of the licensee in connection with any transaction as to which the grounds for suspension, revocation, or refusal related.

(3) The department may allow the licensee, appointee, or continuing education course provider, instructor, school official, or monitor group a reasonable period, not to exceed 30 days, within which to pay to the department the amount of the penalty so imposed. If the licensee, appointee, course provider, instructor, school official, or monitor group fails to pay the penalty in its entirety to the department within the period so allowed, the license, appointments, approval, or status of that person shall stand suspended or revoked or issuance, renewal, or continuation shall be refused, as the case may be, upon expiration of such period.

626.691 Probation.—
(1) If the department finds that one or more grounds exist for the suspension, revocation, or refusal to renew or continue any license or appointment issued under this part, the department may, in its discretion, except when an administrative fine is not permissible under s. 626.681 or when such suspension, revocation, or refusal is mandatory, in lieu of or in addition to such suspension or revocation, or in lieu of such refusal, or in connection with any administrative monetary penalty imposed under s. 626.681, place the offending licensee or appointee on probation for a period, not to exceed 2 years, as specified by the department in its order.
(2) As a condition to such probation or in connection therewith, the department may specify in its order reasonable terms and conditions to be fulfilled by the probationer during the probation period. If during the probation period the department has good cause to believe that the probationer has violated a term or condition, it shall suspend, revoke, or refuse to issue, renew, or continue the license or appointment of the probationer, as upon the original grounds referred to in subsection (1).

624.4211 Administrative fine in lieu of suspension or revocation.—
(1) If the office finds that one or more grounds exist for the discretionary revocation or suspension of a certificate of authority issued under this chapter, the office may, in lieu of such revocation or suspension, impose a fine upon the insurer.
(2) With respect to any nonwillful violation, such fine may not exceed $5,000 per violation. In no event shall such fine exceed an aggregate amount of $20,000 for all nonwillful violations arising out of the same action. If an insurer discovers a nonwillful violation, the insurer shall correct the violation and, if restitution is due, make restitution to all affected persons. Such restitution shall include interest at 12 percent per year from either the date of the violation or the date of inception of the affected person's policy, at the insurer's option. The restitution may be a credit against future premiums due provided that interest accumulates until the premiums are due. If the amount of restitution due to any person is $50 or more and the insurer wishes to credit it against future premiums, it shall notify such person that she or he may receive a check instead of a credit. If the credit is on a policy that is not renewed, the insurer shall pay the restitution to the person to whom it is due.
(3) With respect to any knowing and willful violation of a lawful order or rule of the office or commission or a provision of this code, the office may impose a fine upon the insurer in an amount not to exceed $40,000 for each such violation. In no event shall such fine exceed an aggregate amount of $200,000 for all knowing and willful violations arising out of the same action. In addition to such fines, the insurer shall make restitution when due in accordance with subsection (2).
(4) The failure of an insurer to make restitution when due as required under this section constitutes a willful violation of this code. However, if an insurer in good faith is uncertain as to whether any restitution is due or as to the amount of such restitution, it shall promptly notify the office of the circumstances; and the failure to make restitution pending a determination thereof shall not constitute a violation of this code.