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

December 11, 2012

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

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

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

ITEM	SUBJECT	RECOMMENDATION

1. Minutes of the Financial Services Commission for June 26, 2012 and August 7, 2012.

   (ATTACHMENT 1) **FOR APPROVAL**

2. Request for Approval for Repeal of Rule 69O-164.030; Application of Rule 69O-164.020 to Various Product Designs

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this process, it has been determined that Rule 69O-164.030, Florida Administrative Code, is unnecessary and should be repealed.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

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

3. Request for Approval for Adoption of Proposed Amendments to Rule 69O-137.001;Annual and Quarterly Reporting Requirements and Rule 69O-138.001; NAIC Financial Condition Examiners Handbook Adopted

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

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

4. Request for Approval for Repeal of Rule 69O-143.045; Definitions

   Rule 69O-143.045, Florida Administrative Code, was originally promulgated in the early 1970s. The rule defines a list of insurance terms. Many of the terms defined in the rule are

inconsistent with portions of the Insurance Code. As result of these inconsistencies, this rule should be repealed.

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

5. Request for Approval for Repeal of Rules 69O-157.018; Right to Return Policy-Free Look, 69O-185.005; Advertisement of Mortgage Insurance, 69O-196.008; Failure to Comply, 69O-157.105; Refund of Premium, Rule 69O-198.003; License Required and 69O-170.012; Sinkhole Insurance.

   These rules should be repealed because the laws that they were adopted to implement have been repealed or they substantially restate language contained in the Florida Insurance Code.

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

6. Request for Approval for Adoption of Proposed Amendments to Rule 69O-149.003; Rate Filing Procedures

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

   Rule 69O-149.003(5), Florida Administrative Code, allows insurers without fully credible data to make streamlined rate increase filings with the Office that are simpler in format and content than the full filing format defined in Rule 69O-149.003(2), Florida Administrative Code. Insurers who qualify and elect to file streamlined rate increase filings with the Office are limited to rate increases equal to the maximum annual medical trend for medical expense coverage or the maximum annual medical trend for Medicare Supplement coverage. The current version of Rule 69O-149.003(6), Florida Administrative Code, includes tables which display the applicable maximum annual medical trend. The proposed amendments to Rule 69O-149.003 deletes the aforementioned maximum annual medical trend tables from the text of the rule and provides the URL of the Office's website on which the Office will update the tables as needed.

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

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

7. Request for Approval for Adoption of Proposed Amendments to Rule 69O-149.022; Forms Adopted

   The purpose of this rule is to update and edit the contents of the Universal Standardized Data Letter (UDL) form and instructions used by Life and Health insurers to make electronic form filings via the Office's I-File system. The proposed revisions simplify the reporting entries to reflect the Office's technology. Most of the proposed changes are already in place and have been filed by insurers for some time. As a result, the adoption of these changes by rule will not have a significant economic impact on the insurers that are required to file the revised form.

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

8. Request for Approval for Publication of Proposed Amendments to Rule 69O-170.0155; Forms, 69O-176.013; Notification of Insured's Rights and Standard Disclosure Form; Personal Injury Protection Benefits.

   During the last legislative session, the legislature enacted House Bill 119 (Chapter 2012-197, Laws of Florida), which made significant changes to the provision of Personal Injury Protection ("PIP") benefits in Florida. The proposed changes to Rules 69O-170.0155 and 69O-176.013 make PIP forms adopted in these Rules consistent with the changes to PIP benefits that arose out of the passage of HB 119 (Chapter 2012-197, Laws of Florida).

   Rule 69O-170.0155 adopts form OIR-B1-1809 "Health Care Provider Certification of Eligibility" which requires healthcare professionals providing PIP benefits to certify that they are an eligible PIP provider by filing a copy of the form with insurers upon making an initial claim for PIP medical benefits. The amendments to this form are technical in nature and are designed to conform the form with the language of the statute.

   Rule 69O-176.013 adopts Form OIR-B1-1149 "Notification of Personal Injury Protection Benefits" which is required to be given to PIP claimants upon filing a claim for PIP benefits. This form explains the rights and benefits claimants are entitled to under The Florida Motor Vehicle No-Fault Law. Form OIR-B1-1149 is being revised in accordance with revisions to the PIP law as amended by HB119 (Chapter 2012-197, Laws of Florida). Specifically, the form was revised to reflect that PIP benefits are now allocated for emergency medical treatment and a flat $5,000 death benefit. The form was also revised to incorporate technical edits regarding fraud reporting and billing disclosures.

   (ATTACHMENT 8) **APPROVAL FOR PUBLICATION**

9. Request for Approval for Adoption of Emergency Rule 69OER12-01, "Emergency Adoption of Revised Notification of Personal Injury Protection (PIP) Benefits Form".

   During the 2012 Legislative Session, the Legislature enacted House Bill 119 (Chapter 2012-197, Laws of Florida), which made significant changes to the provisions of Personal Injury Protection ("PIP") benefits in Florida. The effects of the Emergency Rule will allow the Office to adopt Form OIR-ER1-1149 - "Notification of Personal Injury Protection Benefits" on January 1, 2013. This form is designed to notify claimants about the PIP benefits that they are entitled to under the Florida Motor Vehicle No Fault Law.

The current version of the Notification of Personal Injury Protection Benefits accurately describes PIP benefits under the old law but would be inconsistent with the new law. As an example, the current form states that policyholders who have a claim are entitled to $10,000 in PIP benefits. The new form explains that the benefits are limited to $2,500 except under certain circumstances.

The Office believes adopting this form in an emergency rule is the fairest method to protect the public and to assure that insured's are timely notified of their PIP Benefits as required by Florida Law. Furthermore, rulemaking proceedings are being pursued to adopt the Notification of the PIP Rights form on a permanent basis and interested parties will have an opportunity to participate in the standard rulemaking process.

(ATTACHMENT 9) **FOR APPROVAL**

T H E C A B I N E T

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

Representing:

DIVISION OF EMERGENCY MANAGEMENT

ENTERPRISE FLORIDA

OFFICE OF FINANCIAL REGULATION

OFFICE OF INSURANCE REGULATION

CITIZENS PROPERTY INSURANCE

PAROLE COMMISSION

DEPARTMENT OF REVENUE

BOARD OF TRUSTEES, INTERNAL IMPROVEMENT TRUST FUND

DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES

DIVISION OF BOND FINANCE

The above agencies came to be heard before THE FLORIDA CABINET, Honorable Governor Scott presiding, in the Cabinet Meeting Room, LL-03, The Capitol, Tallahassee, Florida, on Tuesday, June 26, 2012, commencing at 9:08 a.m.

Reported by:
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GOVERNOR SCOTT: Next I would like to recognize Commissioner Kevin McCarty with the Office of Insurance Regulation to provide us an update on the status of the Florida property insurance market. Good morning.

COMMISSIONER McCARTY: Good morning, Governor, and Members of the Cabinet. It's a great opportunity today, particularly with Debby making her contribution to the Florida tropical storm season. It's a timely opportunity for me to present to the Financial Services Commission and to the public at large a broad discussion about the state of the Florida homeowners' insurance market.

And I would like our presentation today to focus on three areas. First of all I want to talk about the composition of Florida insurance markets which has really evolved over the years, and it makes Florida unique in the prospect that we really rely very heavily on global reinsurance. So I would also like to also talk about the status of the reinsurance market and how that capital is tapped in and used to pay for catastrophic claims.

And lastly I would like to talk about the

financial conditions of our Florida domestic market. As many of you have know in these presentations that I have made before there are many headwinds that have been facing our domestic market with going many years without making a profit even though we went six years without a hurricane.

Three messages I hope that we take away from today's presentation based upon the evidence presented is despite the challenges we had in the past, and the fact that last year was a record year for catastrophic losses in the reinsurance industry -- as a matter of fact it was the second worse reinsurance year in the history of record keeping in the reinsurance market -- that, first of all, that the financial profitability of the insurance companies has improved and has improved markedly; number 2, international reinsurance markets are reporting extraordinary capital, as a matter of fact additional capital, and actually new vehicles for attracting nontraditional reinsurance capital, which is evidence that even after the catastrophic year as 2011 that capital markets will return to

reinsurance, which is again is critical to our market; and lastly the Florida companies are well positioned this year to face a major catastrophic event.

First of all in discussion of our marketplace, it's important to note that our market has changed pretty dramatically over the years. Since Hurricane Andrew, there's been a very significant exodus of what we call traditional multistate carriers from our marketplace, and about nine months after Hurricane Andrew about 20 percent of the insurance companies exited the marketplace.

In House Bill 1980 the Florida Legislature recognized that indigenous Florida companies and entrepreneurs were going to be critical to the backbone of resuscitating our marketplace and provided $250 million of capital to provide incentives for money to come to Florida. It's been a hugely successful project in that today 60 percent of the business in Florida is indigenous Florida companies, that are Florida-grown companies.

The other 16 percent is traditional mostly out-of-state companies, some of those are also

regional companies, and lastly, of course, about 24 percent of the marketplace is represented by Citizens Property Insurance which accounts for more policies than most of us we would like to see.

Citizens has embarked on a very aggressive program since December of this year with a hundred plus filings to reduce their exposure by reducing the attractiveness of their policies, reducing coverage to cap at a million dollars, reducing pool screens, reducing liability coverage from 300 to 100,000, and there's lot more they have planned, and I'm sure my friend and colleague from Citizens, Mr. Gilway, will explain that in more detail following my presentation.

COMMISSIONER PUTNAM: While you're looking for the next slide, what's the -- Citizens is 24 percent, what's the highest market share of any private insurer?

COMMISSIONER McCARTY: I think that's about 18 percent. I will get those -- I'll get a breakdown of those companies for you. It's Universal P&C is the next largest company.

GOVERNOR SCOTT: About 16.

COMMISSIONER McCARTY: 16.

GOVERNOR SCOTT: About 16.

COMMISSIONER McCARTY: Can I turn this back. I'm having technical trouble. I went one too far here. Let's say previous, that should be self-evident. And there we go.

Okay. For the -- the next slide is to give some indication of the overall surplus of the domestic companies as it's grown over the past four years. If you look at the capital position of our domestic market in 2009, we were at $3.6 billion, $3.8 billion, and then in 2012 that has increased to $3.86 million [sic], and that's an increase of 360 -- $377 million. The purpose of this slide represents that as capital increases so does the ability to increase your capacity to take on additional risks and leverage that with additional reinsurance.

GOVERNOR SCOTT: Commissioner, did the -- was part of the issue the fact that the assessment risk that you could assess 100 percent of surplus in a short period of time, didn't that restrict the amount of surplus people wanted to have in the state?

COMMISSIONER McCARTY: Well, I think that will certainly help going forward.

GOVERNOR SCOTT: And that was eliminated.

COMMISSIONER McCARTY: Yes, it was. There are number of things that we're going to see -- I think that the very next slide, and then some of the other actions that were taken. Clearly what the legislature did in the sinkhole reform in 408 was a harbinger for change in terms of the vision that investors have. But this slide I think evidences it even further.

Overall this slide is very positive. It gives financial performance of the marketplace, you know, that premium earns are up. But if you look at the second to last, one is underwriting gains and underwriting losses. If you look at the slide for the first quarter 2011, it says $9.5 million, and then you look at first quarter 2012 is $39 million. That's a very significant increase. Those are the kinds of signals that are very positive.

Because again, as I said before, let's just go back a couple of years. If you look at -- and I wish I put it on a slide. I didn't think of that until this morning. But if I put

on 2009 first quarter, it would be a minus 65.3 million without a storm. And if you look at 2010 first quarter, it would have been a minus 82.3 without a storm.

And so to go to a positive nine, and then to positive 39, it sends a very positive message. And that is attributable I think to improved underwriting, appropriate pricing, and legislative changes that I think address some very fundamental problems that are not only dealing with sinkhole, but I think with some systemic problems in our system.

The next slide here is to put for the purposes of understanding how just -- that -- that -- the Florida domestic marketplace works. Of course, one of keys to a successful market like Florida is to be able to tap into the reinsurance market. So in a typical company -- and this could be $20 million company or a 60 million company -- will have anywhere from 15 to 20 companies, primarily in Bermuda and primarily in the UK, but not exclusively, but those two financial centers are really have been focused on the Florida marketplace. So they may be supported by 15 or

20 companies.

Those companies may then turn around and retrocess the -- about five or six of that of that to other companies. What this achieves is the globalization of risk. You know, the fundamental concept of insurance is diversification and diversification of risk, underwriting and diversifying. The best way to bring in more capital to Florida is to counterbalance the risk in Florida with a tsunami in Asia, an earthquake in California, and through reinsurance and then reinsuring the reinsurer, you're spreading that risk on a global level, again providing more capital for Florida.

And it's important to understand that many people in the popular press only look at the surplus of the company, and that's very, very misleading. But if look at the $3.8 billion in surplus, that is supported by $19 billion of surplus from the capital markets vis-à-vis reinsurance.

To help articulate this point, you know, you hear a lot about the big, if the big one that hits, if it would happen, well,

reinsurance is a critical component of not only in our state but in many states in the Southeastern United States and the gulf region, according to an RAA report, reinsurers paid 59 billion of the $98 billion in losses due to Hurricanes Rita, Wilma, and Katrina in 2005. Which equates to roughly 60 percent of overall insured losses, which again highlights the importance of diversification and global access to capital markets.

Today a regulatory agency such as ourselves and rating organizations such as A.M. Best and Demotech have been more stringent in the amount of risk companies are allowed to retain. As a matter of fact, Demotech has stated that optimally they would like their insurers not to retain more than 15 percent surplus in catastrophe risk.

This is an overall view of what an individual company would look like. The first level is the company retention level. The second level is what you would purchase through the reinsurance market. This is generally speaking the most expensive part of reinsurance, the piece above the company

retention, but below the attachment point to the Cat Fund. And between the -- the companies have the options of buying 45, 75, or 90. The overwhelming majority of companies purchase the 90 percent so they purchase up along side the Cat Fund, but in addition companies buy a layer above that which is a much less expensive part of equation.

All of these layers -- the point of this is all of these layers are put there to protect the integrity of the surplus of the company. So the fact that you have a storm you don't automatically subtract from that the surplus of the company because only a portion of that is utilized before you penetrate the layers of reinsurance that had been provided.

The expansion of global capital is probably the most -- I think is one of the most interesting phenomena of this year. We thought that after hurricane season 4 and 5, the reinsurance market in Bermuda was devastated. The markets were only able to recapitalize through very, very aggressive pricing, in some cases well over a hundred percent from years before.

Similarly last year was a catastrophic year which had earthquakes in Japan, floods in Thailand, earthquakes in other areas, as well as some of the worse tornadoes in the history of United States, if you remember Joplin, you remember Alabama, yet they were able to capitalize even more this year than the capital that they had in 2011.

When we did a survey in combination with Towers Watson, we -- 12 of the Bermuda reinsurers evidenced an increased interest in providing more coverage to Florida companies. Now, some of them are providing more coverage to individual companies and some are writing more companies in the general. In the London market equally important as Bermuda we had as many as eight companies looking to increase their capacity while 18 said they would maintain their current capacity.

I think one of the other very interesting phenomena is because of some of the challenges that many of the fund managers are experiencing, the Florida marketplace actually looks very attractive in terms of risk diversification. Now, they don't want to take

a lot it, but when you counterbalance that with other risks, and the return on capital that's available, adding Florida exposure was very advisable to fund managers to increase the overall profitability of their fund. So we have another $2.5 billion this year in additional nontraditional reinsurance available for the Florida marketplace.

The Office has also worked very carefully with our colleagues in the Bermuda Monetary Authority. I think a lot of people are concerned how strong are these companies, are they going to be able to make good on their claims. Well, in addition to the rating organizations, these are all solidly rated reinsurance companies, but we also have a sharing arrangement, we have an agreement to work with the Bermuda Monetary Authority, we have bilateral conferences with the Bermuda, we work with the National Association of Insurance Supervisors as well as NAIC to work and to have a better understanding through cooperation and collaboration as to their internal models, as to their estimates, and as to their appetite for risk. And again as I tell you, there is

more and more pressure for reinsurance companies to retain more capital and which is why they're using more -- spreading their risk through retroceding their product as well.

And the last couple of slides really I just wanted to address the overview of our market in particular. Our Office does a comprehensive examination/investigation of the reinsurance program and risk distribution of our companies every year. They comprise of 95 percent of the overall insurance market of the people doing business in Florida and is comprised of three surveys of information.

The first is the preliminary data call. And because of nature of the Florida marketplace, that the Cat Fund starts in Jan -- in July. Our companies are in market in May for their first attempt to negotiate through their broker their first attempts at reinsurance.

We have already received that data, that is being followed up by the actual placements which is called the slips. That's occurred last week, we'll be receiving those, we received some of those last week, we're in the

process analyzing those. And the last one is essentially a reconciliation to ensure that the reinsurance was purchased throughout the hurricane season.

We have reviewed reinsurance programs related to domestic market and found 96 percent of reinsureds had bought at least one in 80-year events with some insurers have insured up to 100 and -- one in 250-year events. This is just based on the preliminary data. We believe that after the analysis of the second data call, that all of our companies will be insured up to one in 80-year event.

I think this is important because I think there's been some misunderstanding by some in the press, I think that they're overly relying on the surplus numbers and not full appreciation on how diversified the risk becomes through the utilization of global capital that our companies are in a very good position.

Depending on who you talk to Hurricane Andrew was one in 33-year storm, a one in 50-year storm, but clearly our companies could withstand a Hurricane Andrew. And when you

speak about Andrew, you know, we lost 10 companies and 20 percent of the market left so we're well-positioned to handle a Hurricane Andrew.

To say in conclusion I have to say that the profitability of our companies have turned around dramatically since the beginning of 2009 when companies were hemorrhaging from losses particularly reopened Wilma claims as well as from the sinkholes. We have turned the corner in that regard, which I think are positive messages to the investment community, not only for start-up companies but for adding capital to our existing companies.

The international reinsurance markets are -- have record capacity since I've been insurance commissioner. I've not seen as much capital in Bermuda and in the UK as I see today. And Florida insurers are well-positioned to respond to the hurricane crisis.

I recently had the opportunity to meet with CEOs from 10, 12 reinsurers in Bermuda as well as seven or eight reinsurers in the United Kingdom and they have all expressed how critically important Florida is to them. They

really are committed to the Florida market. It's very important for them for a number of reasons, it serves obviously as a funding source for them to diversify risk around the globe. They have a lot of confidence in the Florida marketplace today.

I also had an opportunity to meet with the new entrepreneurs, the fund managers as they're looking at some innovative new products that are coming. And this is interesting because this actually offers competition to the reinsurance market. And if you're able to bring more capital in and compete with traditional reinsurance models, that puts downward pressure on rates and hopefully that eventually will bring more stability in our marketplace.

And, you know, the message that they gave to me is that they find Florida to be very attractive, and the message that I gave to them is we appreciate that and Florida is open for business. Thank you very much and appreciate the opportunity to update you.

ATTORNEY GENERAL BONDI: Thank you, Commissioner. Gentlemen, do you have any

questions?

CFO ATWATER: Thank you, General. Appreciate it. Commissioner, back on slide 3 when Commissioner Putnam noted the present market shares in that pie. And I know you have to qualify your answer to this question, but given the changes from Senate Bill 408, given the experiences over the last six or seven years now with wind-related losses, so that's both a question as to underlying policy changes that may related to the matters such as sinkholes and to the lack of events that have occurred on the wind side. Do you see -- or would you be anticipating over the next three to four years the nondomestic insurer is expressing an interest to return or to be more aggressive in marketing in Florida? What would be your forecast there?

COMMISSIONER McCARTY: Well, you know, that's a very good question, CFO Atwater. I think that everyone's business model is very, very different, and I think that you got to remember the nationals are buying reinsurance on a national basis, some of them buy reinsurance on a global basis. They do a lot

of their product development on a national basis.

Florida's policy form, policy rules are very, very different. They would -- they need a different team of experts. Some are willing to make that commitment to understand the complexities of the Florida marketplace, some are not.

I've spoken to a number of CEOs of varying degrees, many of them large companies that had a bigger presence in Florida in the past, and some of them said, yeah, they would be interested in doing it. But it's on the margins and they probably will do that and quite candidly they might put their toe in the water so to speak to see what happens.

There is always concern, and this is the concern that I got in Bermuda, and this is a concern I got in London, is what will be the political reaction in the State of Florida if we have a big event. If we trap capital, there's a moratorium, is there a freeze on rates, you know, so... I think what they like to see is with so much capital available, so much capital making it more affordable and such

positive steps are taken, I think there's an appetite for them to evaluate and maybe make some inroads, but I don't think you're going to see wholesale, heard mentality people coming back to those numbers.

And a lot of that has to do is that the -- the Florida companies that are -- the much maligned Florida companies, many of them have become very, very successful, but they're successful because they've assembled a team of people from underwriting, claims paying, and development of the forms that are Florida -- they've learned -- they cut their teeth in Florida and they understand The Florida Bar, the Florida public defenders, the different environment that Florida is. And so they're better -- they're better honed, they're better sensitized to be able to negotiate difficult challenges that Florida makes to the better extent than a national company would, generally speaking. Generally speaking.

CFO ATWATER: Governor, could I have follow up? Commissioner, in looking at that again pie chart with 24 percent of markets being in Citizens, as we all share that I think

the same sentiment of creating an environment where, in the not too distant future, that market share is less. Who do you see absorbing that -- then the question would be in the initiatives to depopulate -- will that absorption come from Florida domestics or would we -- would we expect to see that market share from the nondomestic that maybe seeing changes in Florida look to be a more rational in the significant losses that were taking place during sinkhole fraud, clearly a tremendous amount of sinkhole fraud that was taking place in claims. Where do you see that absorption taking place?

COMMISSIONER McCARTY: Well, you know, I had some preconceived notations as to what I thought that was, but I thought it would be better positioned if I asked some of the experts that would put up the money, which were that some of the CEOs of some of the largest companies, and their familiarity in terms of their relationships in terms Florida are with the Florida companies. I think what they would like to see is to take the additional capacity and help either in an indirect way, whether

it's to increase quota share, increase -- so they would take companies -- and the management teams that they have become familiar with, comfortable with over the years.

Now, many of these companies support the national companies as well. But in terms of their -- when they come and make their pitch for reinsurance, it's the folks who have been on the grounds, paid claims through hurricane seasons, understood the nuances of non-Cat losses, they're concerned about the non-Cat losses as much as the Cat losses because they want your company to be around to buy reinsurance from them in the future.

I think their -- I think the confidence will be in potentially new Cat companies, but that's kind of hard because you're untested and so they're going to be a little tepid in how much that comes in. But if you were to ask them to take this additional capacity and at the right price -- and that's really important, because it's there and it's there in a very significant quantity, but not at any price, at the right price -- they would deploy it to some of the people that they had the best

relationships with in the last seven to 10 years.

That doesn't mean to dismiss that they're willing to come back in. I just don't think they would come back in the large numbers to counterbalance what would -- what would be absorbed from the Florida domestic market.

CFO ATWATER: Commissioner, there has been some comments that we've probably all had access to read, a very recent regarding our ability to respond to the -- to the filings of forms following 408, and I appreciate that you maybe expressed a concern as to the quality of some of that. Is there anything that you would wish to ask of us as far as necessary resources, temporarily shifting of support in resources? I know what your team does is very -- has an extraordinary level of expertise to do that, so it's not as if we can shift over any individual to try to help. But is there anything that you would -- you would need from us? Just offer some commentary on that -- on that -- on that feedback. Is there anything we can do to be more supportive?

COMMISSIONER McCARTY: Sure. And this is

a problem that we've been cognizant of. When we deregulated rates on -- commercial rates, our policy forms increased 41 percent in a one-year period, you know. So we've had a huge -- and I'm not here to make excuses, I'm here to explain how we tried to address this issue.

On May 9th of last -- of this year we issued an order, I think that was crediting my legal team for their creativity which allowed the companies to certify the accuracy of the information. There are a number of companies who feel as though they've made a few relatively changes and there's no reason to hold up those filings. We did a similar order yesterday on -- of pending filings, as well as future filings.

We redeployed resources from several other areas of the Department to go in the forms area; we established a training forum so that we could oversee so we could expedite the filings getting out the door; we did a filing conference, which was really a business development conference a week, a week and a half ago to sit down in a room with the people

who do the filings and say here are things that we don't understand that's in the filing that we think would be better, and what can we do better, is there something that we could do better to help you help us. I think we're on the right track, and I think that we will take whatever resources that are necessary.

Some of these -- some of these forms are very complex. When you finally have permission from your IT Department to make a holistic change of your form, you don't necessarily put in your 10 408 forms, you probably put in 54 other changes that you wanted to make at that time. So the complexity of the filings vary a great deal.

There are some companies that benefit from sitting down with one of our seasoned analyst -- not all of them are seasoned, with one of our seasoned analysts -- and share their experiences so some of other the policy forms have had very good luck with the way they've defined water seepage, or the way they defined a sublimit on another policy, and want the benefit of some of the court cases that they may not be aware of, that we are aware of so

that we can to help them prevent -- produce a product that prevents them from litigation in the future.

But not all companies want that service. So we want to offer them a -- the blend. We want to offer to be able to sit down and provide that consultive service if they want it, but on the other hand, if they want to fast track it, certify it, just say this the one part we're changing, we're going to provide that opportunity as well.

CFO ATWATER: So you would let us know if there is anything we can do to help.

COMMISSIONER McCARTY: Well, in an ideal world, you know, we went to the legislature when this problem was first identified, said you can deregulate the rates. There were a number of companies for a variety of reasons that didn't want that done, there were some consumers that didn't want that done. We could use a little technology upgrades that would help us. Forms are very, very complex, you might have one form that affects 25 or 30 different filings, so if we could have some tools, additional tools in our technology, that

would be great.

And to be very candid with you, these workloads of some these people are 250, 300 form filings, they burn out on. So if I could pay people some more money, I could probably make them do more. You're not in the legislature now, sir, I know if you were, you would help me get those resources.

GOVERNOR SCOTT: All right. Anything else?

CFO ATWATER: No.

GOVERNOR SCOTT: Thank you very much.

COMMISSIONER McCARTY: Thank you.

GOVERNOR SCOTT: Have a good day.

COMMISSIONER McCARTY: Appreciate it.

T H E C A B I N E T

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

Representing:

DIVISION OF BOND FINANCE

STATE BOARD OF ADMINISTRATION

FINANCIAL SERVICES COMMISSION, INSURANCE REGULATION

DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES

The above agencies came to be heard before THE FLORIDA CABINET, the Honorable Governor Scott presiding, in the Cabinet Meeting Room, LL-03, The Capitol, Tallahassee, Florida, on Tuesday, August 7, 2012, commencing at approximately 9:20 a.m.

Reported by:

MARY ALLEN NEEL
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Florida Professional Reporter
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GOVERNOR SCOTT: Now I would like to recognize Commissioner Kevin McCarty with the Office of Insurance Regulation.

Good morning, Kevin.

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

At your request, Governor, and the request of the Cabinet, the Office has undertaken a comprehensive review of our rules and regulations and identified several areas where they may be burdensome, redundant, unnecessary, or outdated, and therefore should be considered for repeal. Today's agenda has five of those rules for notice of repeal. While we've undertaken the review, Governor, the Office has been careful to make sure that the repeal of these rules does not justify existing consumer protections under Florida law.

With that, I submit to you request number one, approval for publication of notice of repeal of Rule 690-148.001, funding for pre-need contracts with life annuities. This rule essentially restates the rule and is -- the amounts stated in the rule are inconsistent with Florida Statutes. Therefore, we would like to request repeal of the rule.

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

COMMISSIONER PUTNAM: So moved.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Moved and seconded. The item is approved without objection.

MR. McCARTY: Agenda Item Number 2 is request for approval for publication of notice of repeal of Rule 690.196.008, failure to comply. This rule states that the failure of a premium finance company to comply with certain requirements of Chapter 627 of Florida Statutes may be subject to action by the Office. This rule substantially restates the language already provided under Florida law, and as a result, repeal of this rule is requested.

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

COMMISSIONER PUTNAM: So moved.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Moved and seconded. The item is approved without objection.

MR. McCARTY: Agenda Item Number 3 is request

for approval for publication of notice of repeal of Rule 690.157.018, Right to Return Policy - Free Look. This rule substantially restates the language in Chapter 627, Florida Statutes, and is unnecessary. As a result, the Office requests repeal of the rule.

GOVERNOR SCOTT: Why don't we do 3, 4, and 5 all together.

MR. McCARTY: Okay. Rule 4 is request for repeal of the advertisement of mortgage insurance. This rule also substantially restates the language of Chapter 634 and is unnecessary, and we request repeal.

And the refund of premium financed was request for approval for publication of Rule 690-157.105. This rule requires insurers who cancel insurance policies to refund to the policyholder. This substantially restates the rules existing in Florida law and is unnecessary, and as a result, the Office requests repeal this rule as well.

GOVERNOR SCOTT: Go ahead and do the last one.

MR. McCARTY: That's it, sir.

GOVERNOR SCOTT: Oh, that's it? Okay. Is there a motion to approve these items?

ATTORNEY GENERAL BONDI: Move Items 3, 4, and

5, Governor.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Moved and seconded. These items are approved without objection.

Kevin, you want to tell them what's happening with regard to how the -- what you're able to do to expedite some of the filings?

MR. McCARTY: Yes, sir. We have undertaken a number of initiatives. We've reassigned four or five analysts to -- from other areas to expedite the filings. We also published two orders, one substantially dealing with commericial, the other order dealing substantially with commercial auto and homeowners, which would allow companies to certify that their forms are in compliance with Florida law, and therefore can put them in the commerce stream without subject to any delay.

GOVERNOR SCOTT: Thanks, Kevin.

MR. McCARTY: You're welcome, Governor.

Michelle Rivieto
Approved
Date September 10 2012

M E M O R A N D U M

DATE: September 7, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill DT
Jason Nelson JN

SUBJECT: Cabinet Agenda for December 11, 2012
Request for Final Approval of Repeal of
Rule 69O-164.030
Application of Rule 69O-164.020 to Various Product Designs
Assignment 122864-12

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before October 17, 2012 and to the Financial Services Commission on October 23, 2012, with a request for Final Approval to Repeal Rule 69O-164.030. A notice of the Final Rule Hearing will be published in the *Florida Administrative Weekly* on September 21,2012.

The notice of proposed rule repeal was published on July 20, 2012 in Volume 38, No. 29, of the *Weekly*. A hearing was not requested, therefore, a hearing was not held. No Changes have been made.

The Office of Insurance Regulation has recently conducted a comprehensive review of all agency rules to determine whether any of its rules should be modified or eliminated. As a result of this process, it has been determined that Rule 69O-164.030, Florida Administrative Code, is unnecessary and should be repealed.

The National Association of Insurance Commissioners ("NAIC") Accounting Practices and Procedures Manual was adopted by the Office in Rule 69O-137.001, Florida Administrative Code. The purpose of Rule 69O-164.030, Florida Administrative Code, is to allow the Office to deviate from step 8A through step 8C of Actuarial Guideline 38 which is contained in Volume II Appendix C of the NAIC Accounting Practices and Procedures Manual.

Actuarial Guideline 38 deals with reserving approaches that need to be established for guarantees that are provided by a policy. Steps 8A through 8C deal with reserves for universal life policy guarantees.

Pursuant to the Accounting Practices and Procedures Manual:

- step 8A applies to universal life policies issued prior to July 1, 2005
- step 8B applies to universal life policies issued on or after July 1, 2005 and prior to December 31, 2006. Step 8B also applies to universal life policies issued after January 1, 2014
- step 8C applies to universal life policies issued on or after January 1, 2007 and prior to December 31, 2013.

Based upon the text of Actuarial Guideline 38 contained in the Accounting Practices and Procedures Manual, all universal life policies issued after January 1, 2014 would have to meet the reserve standards laid out in step 8B. The Office feels that it would be in the best interest of Florida consumers to have 8A to apply to universal life policies when step 8C is no longer available (currently January 1, 2014) instead of step 8B. The purpose of Rule 69O-164.030, Florida Administrative Code, is to achieve the Office's goal of deviating from Actuarial Guideline 38. The net effect of the Rule is to have step 8A apply to universal life policies when step 8C is no longer available instead of having 8B apply.

It now appears that the NAIC will continue to extend the expiration date of step 8C indefinitely. As a result, Rule 69O-164.030, Florida Administrative Code is not necessary.

Sections 624.308(1), 625.121(5), 624.307(1), 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 rule has been completed.

Jason Nelson is the attorney handling this rule. Attached are: 1) the 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-164.030 Application of Rule 69O-164.020, F.A.C., to Various Product Designs

Specific Authority 624.308(1), 625.121(5) FS. Law Implemented 624.307(1), 625.121(5) FS. History–New 5-4-06, Amended 1-16-08, Repealed.

69O-164.030 Application of Rule 69O-164.020, F.A.C., to Various Product Designs.

(1) Purpose. The purpose of this rule is to provide direction as to the application of Rule 69O-164.020, F.A.C., to various product designs developed after March, 1999. Specifically, this rule provides examples of various policy features that constitute "guarantees" and gives directions on how to reserve for these guarantees in accordance with Rule 69O-164.020, F.A.C. Obviously, new policy designs will emerge subsequent to the development of this rule. No statute, rule, or guideline can anticipate every future product design, and common sense and professional responsibility are needed to assure compliance with both the letter and the spirit of the law. While Rule 69O-164.020, F.A.C., is a complex regulation, its intent is clear: reserves need to be established for the guarantees provided by a policy. Policy designs that are created to simply disguise those guarantees or exploit a perceived loophole must be reserved in a manner similar to more typical designs with similar guarantees.

(2) Application. The list below specifies reserving approaches which the Office regards as being most consistent with the letter and spirit of Rule 69O-164.020, F.A.C. However, the specified reserving approaches should be modified as needed to comply with the intent of this rule that similar reserves be established for policy designs that contain similar guarantees.

(a)1. Situation: An initial level premium rate is guaranteed for 10 years followed by increased guaranteed premiums for an additional 20 years. However, the company cannot increase premiums after year 10 (i.e., the initial premium continues to be charged) unless some specified event occurs.

2. Application: The initial reserve segment is 30 years. Since the contract contains provisions that limit the company's ability to increase premiums, then the initial premium should be treated as guaranteed for the entire 30 year period. It would be contrary to the conservative nature of statutory accounting to treat this policy the same as one in which the ability to raise premiums is unrestricted.

(b)1. Situation: A term policy has an illustrated level premium for 30 years, the first 10 of which are guaranteed. Additionally, there is a refund option which provides that a specified refund will be paid if the premium ever increases. The refund must be requested within a limited time (e.g., 30 days) of receiving notice of the increase. Coverage terminates if the option is exercised.

2. Application: This example differs from the one above in that there is no specified event that has to occur in order for the company to impose a premium increase; however, the company must provide an additional benefit to the policyholder if it exercises this right. Thus the company does not have an unrestricted right to impose an increase after 10 years. If the contract contains provisions that require that additional benefits be provided to the policyholder in the event of a premium increase, even if these benefits are lost if not claimed within a stated time frame, then the initial premiums should be treated as guaranteed for the entire 30 year period. It would be contrary to the conservative nature of statutory accounting to treat this policy the same as one in which the ability to raise premiums does not require that additional benefits be provided. Therefore, the initial segment for this policy is 30 years.

(c)1. Situation: An initial level premium rate is guaranteed for 10 years followed by increased guaranteed premiums for an additional 20 years. However, after year 10 the policyholder is protected against premiums being increased above the initial level, with the protection provided by a second company through either reinsurance, a second policy issued to the consumer, or an agreement between the companies.

2. Application: The combined reserves of the direct writer and the second company should be no less than the amount which the direct writer would hold if a) there were no second company and b) the initial reserve segment were 30 years. If this condition is not met, reserve credits for the direct writer should be disallowed. The reserve held by the direct writer should be based on the initial level premium being guaranteed for 30 years.

(d)1. Situation: A product has relatively high gross premiums but with a guaranteed dividend or guaranteed refund schedule, or by some other means guarantees a low net cost to the policyholder.

2. Application: The net amount of premium (i.e., gross premium less dividends or refunds) should be used in the reserve calculation. That represents the amount the insured actually pays for coverage. For products reinsured on either a coinsurance or modified coinsurance basis, the reinsurer's reserve calculation should also be based on the net premium (i.e., gross premiums less dividends or refunds guaranteed to be paid to the policyholder).

(e)1. Situation: A re-entry term product has an initial rate guarantee for 10 years, with loose or non-existent re-entry underwriting, allowing the policyholder to re-enter for an additional 20 years at specified favorable rates.

2. Application: The reentry periods and premiums should be treated as a continuation of the initial guarantees for reserve calculation purposes. The initial reserve segment applicable to the original policy should be 30 years if the stipulated premium for the substitute policy is not high enough to trigger a new reserve segment. When the substitute policy is issued, reserves should be determined as if the coverage had been issued at the issue age and issue date of the original policy. Effectively, the company has

guaranteed coverage for 30 years at the time the initial policy is issued, and the reserves established should reflect that guarantee.

(f)1. Situation: A universal life policy has provisions such that, if the UL policy lapses prior to the 10th policy anniversary because the actual accumulation value (or cash value, depending on design) falls below zero but stipulated premiums have been paid, a substitute policy is guaranteed to be issued providing the same amount of insurance coverage at the same stipulated premium for the remainder of the 10-year period plus an additional 20 years.

2. Application: The reentry periods and premiums should be treated as a continuation of the initial guarantees for reserve calculation purposes. The initial reserve segment applicable to the original policy should be 30 years if the stipulated premium for the substitute policy is not high enough to trigger a new reserve segment. When the substitute policy is issued, reserves should be determined as if the coverage had been issued at the issue age and issue date of the original policy. Effectively, the company has guaranteed coverage for 30 years at the time the initial policy is issued, and the reserves established should reflect that guarantee.

(g)1. Situation: A reinsurance treaty provides for 30 years of level premiums on a current scale but directly guarantees those premiums for only the first 10 years. However, if the reinsurer increases the premiums after 10 years, the reinsurer agrees to increase the expense allowance such that the net payments (premium minus allowance) by the direct writer remains unchanged.

2. Application: Relative to the reinsurer's reserve calculation, the initial reserve segment should be 30 years and the valuation premium should be level over that period. In this instance, the additional "expense allowance" has no relationship to the expenses actually incurred by the direct writer in administering the reinsured policies. Although a bona fide expense allowance would typically not be considered in determining the valuation premiums and reserve segments, in this instance the additional "expense allowance" has no relationship to the expenses actually incurred by the direct writer in administering the reinsured policies."

(h)1. Situation: A universal life policy has a cumulative "premium catch-up provision" in which the coverage is guaranteed to remain in force as long as a stipulated premium is paid each year, and if the insured is paying less than is required to maintain the guarantee, there is an unlimited right to make up past premium deficiencies.

2. Application: Rule 69O-164.020, F.A.C., requires that "when a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees." Since secondary guarantees with "catch-up" provisions are capable of being reinstated up to the end of the secondary guarantee period, they constitute "unexpired secondary guarantees" which must be incorporated into the calculation of "the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees."

3. The basic and deficiency reserves for a secondary guarantee with a catch-up provision should be computed as if the stipulated premium requirement had been met. The basic reserve shall be reduced by the product of a) the "catch-up amount," if any, which would be required on the valuation date and b) the ratio of the "initial" (i.e., before adjustment) basic reserve to the sum of the "initial" basic and deficiency reserves. In no event shall the "reduced" basic reserve be reduced below zero. The deficiency reserve shall be reduced by the product of a) the "catch-up amount," if any, which would be required on the valuation date and b) the ratio of the "initial" deficiency reserve to the sum of the "initial" basic and deficiency reserves. In no event shall the "reduced" deficiency reserve be reduced below zero.

4. If a universal life policy with a "premium catch up provision" has a shadow account below the level necessary to maintain the secondary guarantee, then the reserve for the secondary guarantee shall be valued according to this example. The basic and deficiency reserves, before deduction for the catch-up amount, shall be calculated as specified in paragraph (i).

(i) A universal life policy guarantees the coverage to remain in force as long as the accumulation of premiums paid satisfies the secondary guarantee requirement.

1. For policies and certificates issued prior to July 1, 2005, and for policies and certificates issued on or after January 1, 2011:

a. First, the minimum gross premiums (determined at issue) that will satisfy the secondary guarantee requirement must be derived.

b. Second, for purposes of applying paragraphs (7)(b) and (c) of Rule 69O-164.020, F.A.C., the "specified premiums" are the minimum gross premiums derived in sub-subparagraph a.

c. Third, a determination should be made of the amount of actual premium payments in excess of the minimum gross premiums. For policies utilizing shadow accounts, this will be the amount of the shadow account. For policies with no shadow accounts but which specify cumulative premium requirements, this excess will be the amount of the cumulative premiums paid in excess of the cumulative premium requirements; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee).

d. Fourth, a determination should be made of the single payment necessary at the valuation date to fully fund the remaining secondary guarantee assuming that the minimum gross premiums have been paid, up through the valuation date, during the secondary guarantee period. The result from sub-subparagraph c. should be divided by this number.

e. Fifth, compute the net single premium on the valuation date for the coverage provided by the secondary guarantee for the remainder of the secondary guarantee period, using any valuation table and select factors authorized in paragraph (5)(a) of Rule 69O-164.020, F.A.C.

f. Sixth, the "net amount of additional premiums" is determined by multiplying the ratio from sub-subparagraph d. by the difference between the net single premium from sub-subparagraph e. and the basic and deficiency reserve, if any, computed in sub-subparagraph b.

g. Seventh, a "reduced deficiency reserve" should be computed by multiplying the deficiency reserve, if any, by one minus the ratio from sub-subparagraph d., but not less than zero. This "reduced deficiency reserve" is the deficiency reserve to be used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C.

h. Eighth, the actual reserve used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C., is the lesser of: (1) the net single premium from sub-subparagraph e., and (2) the amount of the excess from sub-subparagraph f., plus the basic reserve and the deficiency reserve, if any, computed in sub-subparagraph b. Reduce this result by the applicable policy surrender charges, i.e., the account value less the cash surrender value. If the resulting amount is less than the sum of the basic and deficiency reserve from sub-subparagraph b., then the basic and deficiency reserves to be used for the purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C., are those calculated in sub-subparagraph b., and no further calculation is required.

i. Ninth, an "increased basic reserve" should be computed by subtracting the "reduced deficiency reserve" in sub-subparagraph g. from the reserve computed in sub-subparagraph h. This "increased basic reserve" is the basic reserve to be used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C.

2. For policies and certificates issued on or after July 1, 2005, and prior to January 1, 2007:

a. First, the minimum gross premiums (determined at issue) that will satisfy the secondary guarantee requirement must be derived.

b. Second, for purposes of applying paragraphs (7)(b) and (7)(c) of Rule 69O-164.020, F.A.C., the "specified premiums" are the minimum gross premiums derived in sub-subparagraph a. consistent with Rule 69O-164.020, F.A.C., the remaining sub-subparagraphs in this rule should be calculated on a segmented basis, using the segments that Rule 69O-164.020, F.A.C., defines for the product. Therefore, in the remaining sub-subparagraphs, the term "fully fund the guarantee" should be interpreted to mean fully funding the guarantee to the end of each possible segment. The term "remainder of the secondary guarantee period" should be interpreted to mean the remainder of each possible segment. The total reserve should equal the greatest of all possible segmented reserves.

c. Third, a determination should be made of the amount of actual premium payments in excess of the minimum gross premiums. For policies utilizing shadow accounts, this will be the amount of the shadow account. For policies with no shadow accounts but which specify cumulative premium requirements, this excess will be the amount of the cumulative premiums paid in excess of the cumulative premium requirements; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee).

d. Fourth, as of the valuation date for the policy being valued, for policies utilizing shadow accounts, determine the minimum amount of shadow account required to fully fund the guarantee. For policies with no shadow accounts but which specify cumulative premium requirements, determine the amount of the cumulative premiums paid in excess of the cumulative premium requirements that would result in no future premium requirements to fully fund the guarantee; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee). For any policy for which the secondary guarantee can not be fully funded in advance, solve for the minimum sum of any possible excess funding (either the amount in the shadow account or excess cumulative premium payments depending on the product design) and the present value of future premiums (using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves) that would fully fund the guarantee. The amount determined above for this sub-subparagraph is to then be divided by one minus a seven percent premium load allowance (0.93). The result from sub-subparagraph c. should be divided by this number, with the resulting ratio capped at 1. The ratio is intended to measure the level of prefunding for a secondary guarantee which is used to establish reserves. Assumptions within the numerator and denominator of the ratio therefore must be consistent in order to appropriately reflect the level of prefunding. The denominator is allowed to be

inconsistent only by the amount of the premium load allowance as defined in this sub-subparagraph. As used here, "assumptions" include any factor or value, whether assumed or known, which is used to calculate the numerator or denominator of the ratio.

e. Fifth, compute the net single premium on the valuation date for the coverage provided by the secondary guarantee for the remainder of the secondary guarantee period, using any valuation table and select factors authorized in paragraph (5)(a) of Rule 69O-164.020, F.A.C.

f. Sixth, the "net amount of additional premiums" is determined by multiplying the ratio from sub-subparagraph d. by the difference between the net single premium from sub-subparagraph e. and the basic and deficiency reserve, if any, computed in sub-subparagraph b.

g. Seventh, a "reduced deficiency reserve" should be computed by multiplying the deficiency reserve, if any, by one minus the ratio from sub-subparagraph d., but not less than zero. This "reduced deficiency reserve" is the deficiency reserve to be used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C.

h. Eighth, the actual reserve used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C., is the lesser of: (1) the net single premium from sub-subparagraph e., and (2) the amount of the excess from sub-subparagraph f. plus the basic reserve and the deficiency reserve, if any, computed in sub-subparagraph b. Reduce this result by the applicable policy surrender charges, i.e., the account value less the cash surrender value. Multiply the applicable policy surrender charge by the ratio of the net level premium for the secondary guarantee period divided by the net level premium for whole life insurance. Calculate both net premiums using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves. However, if no future premiums are required to support the guarantee period being valued, there is no reduction for surrender charges. If the resulting amount is less than the sum of the basic and deficiency reserve from sub-subparagraph b., then the basic and deficiency reserves to be used for the purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C., are those calculated in sub-subparagraph b., and no further calculation is required.

i. Ninth, an "increased basic reserve" should be computed by subtracting the "reduced deficiency reserve" in sub-subparagraph g. from the reserve computed in sub-subparagraph h. This "increased basic reserve" is the basic reserve to be used for purposes of subparagraph 69O-164.020(7)(d)1., F.A.C.

3. For policies and certificates issued on or after January 1, 2007, and prior to January 1, 2011:

a. First, the minimum gross premiums (determined at issue) that will satisfy the secondary guarantee requirement must be derived.

b. Second, for purposes of applying paragraphs (7)(b) and (7)(c) of Rule 69O-164.020, F.A.C., the "specified premiums" are the minimum gross premiums derived in sub-subparagraph a.

(I) Consistent with Rule 69O-164.020, F.A.C., the remaining sub-subparagraphs in this rule should be calculated on a segmented basis, using the segments that Rule 69O-164.020, F.A.C., defines for the product. Therefore, in the remaining sub-subparagraphs, the term "fully fund the guarantee" should be interpreted to mean fully funding the guarantee to the end of each possible segment. The term "remainder of the secondary guarantee period" should be interpreted to mean the remainder of each possible segment. The total reserve should equal the greatest of all possible segmented reserves.

(II) Additionally, for purposes of applying paragraphs (7)(b) and (c) of Rule 69O-164.020, F.A.C., a lapse rate of no more than 2% per year for the first 5 years, followed by no more than 1% per year to the policy anniversary specified in the following table based on issue age, and 0% per year thereafter may be used. If the duration in the table is less than 5, then a lapse rate of no more than 2% per year may be used through that duration, and 0% per year thereafter.

Issue Age	Duration
0 – 50	30th Policy Anniversary
51 – 60	Policy Anniversary Age 80
61 – 70	20th Policy Anniversary
71 – 89	Policy Anniversary Age 90
90 and over	No Lapse

c. Third, a determination should be made of the amount of actual premium payments in excess of the minimum gross premiums. For policies utilizing shadow accounts, this will be the amount of the shadow account. For policies with no shadow accounts but which specify cumulative premium requirements, this excess will be the amount of the cumulative premiums paid in excess of the cumulative premium requirements; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee).

d. Fourth, as of the valuation date for the policy being valued, for policies utilizing shadow accounts, determine the minimum amount of shadow account required to fully fund the guarantee. For policies with no shadow accounts but which specify cumulative premium requirements, determine the amount of the cumulative premiums paid in excess of the cumulative premium requirements that would result in no future premium requirements to fully fund the guarantee; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee). For any policy for which the secondary guarantee cannot be fully funded in advance, solve for the minimum sum of any possible excess funding (either the amount in the shadow account or excess cumulative premium payments depending on the product design) and the present value of future premiums (using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves) that would fully fund the guarantee. The amount determined above for this sub-subparagraph is to then be divided by one minus a seven percent premium load allowance (0.93). The result from sub-subparagraph c. should be divided by this number, with the resulting ratio capped at 1. The ratio is intended to measure the level of prefunding for a secondary guarantee which is used to establish reserves. Assumptions within the numerator and denominator of the ratio therefore must be consistent in order to appropriately reflect the level of prefunding. The denominator is allowed to be inconsistent only by the amount of the premium load allowance as defined in this sub-subparagraph. As used here, "assumptions" include any factor or value, whether assumed or known, which is used to calculate the numerator or denominator of the ratio.

e. Fifth, compute the net single premium on the valuation date for the coverage provided by the secondary guarantee for the remainder of the secondary guarantee period, using any valuation table and select factors authorized in paragraph (5)(a) of Rule 69O-164.020, F.A.C. For purposes of calculating the net single premium, a lapse rate subject to the same criteria as the lapse rate used in applying paragraph b. above may be used.

f. Sixth, the "net amount of additional premiums" is determined by multiplying the ratio from sub-subparagraph d. by the difference between the net single premium from sub-subparagraph e. and the basic and deficiency reserve, if any, computed in sub-subparagraph b.

g. Seventh, a "reduced deficiency reserve" should be computed by multiplying the deficiency reserve, if any, by one minus the ratio from sub-subparagraph d., but not less than zero. This "reduced deficiency reserve" is the deficiency reserve to be used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C.

h. Eighth, the actual reserve used for purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C., is the lesser of: (1) the net single premium from sub-subparagraph e., and (2) the amount of the excess from sub-subparagraph f., plus the basic reserve and the deficiency reserve, if any, computed in sub-subparagraph b.

(I) Reduce this result by the applicable policy surrender charges, i.e., the account value less the cash surrender value.

(II) Multiply the applicable policy surrender charge by the ratio of the net level premium for the secondary guarantee period divided by the net level premium for whole life insurance.

(III) Calculate both net premiums using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves. However, if no future premiums are required to support the guarantee period being valued, there is no reduction for surrender charges.

(IV) Multiply this surrender charge by the ratio of the net level premium for the secondary guarantee period divided by the net level premium for whole life insurance. Calculate both net premiums using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves.

(V) If the resulting amount is less than the sum of the basic and deficiency reserve from sub-subparagraph b., then the basic and deficiency reserves to be used for the purposes of subparagraph (7)(d)1. of Rule 69O-164.020, F.A.C., are those calculated in sub-subparagraph b., and no further calculation is required.

i. Ninth, an "increased basic reserve" should be computed by subtracting the "reduced deficiency reserve" in sub-subparagraph g. from the reserve computed in sub-subparagraph h. This "increased basic reserve" is the basic reserve to be used for purposes of subparagraph 69O-164.020(7)(d)1., F.A.C.

j. Business reserved pursuant to (2)(i)3. of this rule must be supported by an asset adequacy analysis specific to this business.

(I) This asset adequacy analysis must be performed pursuant to the requirements of Section 625.121(3), FS.

(II) Reserves required by subparagraph (2)(i)3. of this rule, plus any additional reserves required by the asset adequacy analysis, shall be the minimum reserves for this business.

(3) Effective Date.

(a) The application of this rule shall be to policies issued on or after December 24, 2003.

(b) Subparagraph (2)(i)2. shall apply to all policies and certificates issued on or after July 1, 2005.

Specific Authority 624.308(1), 625.121(5) FS. Law Implemented 624.307(1), 625.121(5) FS. History–New 5-4-06, Amended 1-16-08.

624.308 Rules.—

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

625.121 Standard Valuation Law; life insurance.—

(5) MINIMUM STANDARD FOR VALUATION OF POLICIES AND CONTRACTS ISSUED ON OR AFTER OPERATIVE DATE OF STANDARD NONFORFEITURE LAW.—Except as otherwise provided in paragraph (h) and subsections (6), (11), and (14), the minimum standard for the valuation of all such policies and contracts issued on or after the operative date of s. 627.476 (Standard Nonforfeiture Law for Life Insurance) shall be the commissioners' reserve valuation method defined in subsections (7), (11), and (14); 5 percent interest for group annuity and pure endowment contracts and 3.5 percent interest for all other such policies and contracts, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after July 1, 1973, 4 percent interest for such policies issued prior to October 1, 1979, and 4.5 percent interest for such policies issued on or after October 1, 1979; and the following tables:

(a) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies:

1. For policies issued prior to the operative date of s. 627.476(9), the commissioners' 1958 Standard Ordinary Mortality Table; except that, for any category of such policies issued on female risks, modified net premiums and present values, referred to in subsection (7), may be calculated according to an age not more than 6 years younger than the actual age of the insured.

2. For policies issued on or after the operative date of s. 627.476(9), the commissioners' 1980 Standard Ordinary Mortality Table or, at the election of the insurer for any one or more specified plans of life insurance, the commissioners' 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors.

3. For policies issued on or after July 1, 2004, ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for such policies.

(b) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies:

1. For policies issued prior to the first date to which the commissioners' 1961 Standard Industrial Mortality Table is applicable according to s. 627.476, the 1941 Standard Industrial Mortality Table; and

2. For such policies issued on or after that date, the commissioners' 1961 Standard Industrial Mortality Table.

(c) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 Standard Annuity Mortality Table or, at the option of the insurer, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the office.

(d) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the Group Annuity Mortality Table for 1951; any modification of such table approved by the office; or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts:

1. For policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the Society of Actuaries, with due regard to the type of benefit;

2. For policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either those tables or, at the option of the insurer, the class three disability table (1926);
3. For policies issued prior to January 1, 1961, the class three disability table (1926); and
4. For policies or contracts issued on or after July 1, 2004, tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for those policies or contracts.

Any such table for active lives shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies:
1. For policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table;
2. For policies issued on or after January 1, 1961, and prior to January 1, 1966, either that table or, at the option of the insurer, the Intercompany Double Indemnity Mortality Table;
3. For policies issued prior to January 1, 1961, the Intercompany Double Indemnity Mortality Table; and
4. For policies issued on or after July 1, 2004, tables of accidental death benefits adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for those policies.

Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(g) For group life insurance, life insurance issued on the substandard basis, and other special benefits, such tables as may be approved by the office as being sufficient with relation to the benefits provided by such policies.
(h) Except as provided in subsection (6), the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this paragraph and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts shall be the commissioners' reserve valuation method defined in subsection (7) and the following tables and interest rates:
1. For individual annuity and pure endowment contracts issued prior to October 1, 1979, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the office, and 6 percent interest for single-premium immediate annuity contracts and 4 percent interest for all other individual annuity and pure endowment contracts.
2. For individual single-premium immediate annuity contracts issued on or after October 1, 1979, and prior to October 1, 1986, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the office, and 7.5 percent interest. For such contracts issued on or after October 1, 1986, the 1983 Individual Annual Mortality Table, or any modification of such table approved by the office, and the applicable calendar year statutory valuation interest rate as described in subsection (6).
3. For individual annuity and pure endowment contracts issued on or after October 1, 1979, and prior to October 1, 1986, other than single-premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the office, and 5.5 percent interest for single-premium deferred annuity and pure endowment

contracts and 4.5 percent interest for all other such individual annuity and pure endowment contracts. For such contracts issued on or after October 1, 1986, the 1983 Individual Annual Mortality Table, or any modification of such table approved by the office, and the applicable calendar year statutory valuation interest rate as described in subsection (6).

4. For all annuities and pure endowments purchased prior to October 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any modification of this table approved by the office, and 6 percent interest.
5. For all annuities and pure endowments purchased on or after October 1, 1979, and prior to October 1, 1986, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any modification of this table approved by the office, and 7.5 percent interest. For such contracts purchased on or after October 1, 1986, the 1983 Group Annuity Mortality Table, or any modification of such table approved by the office, and the applicable calendar year statutory valuation interest rate as described in subsection (6).

After July 1, 1973, any insurer may have filed with the former Department of Insurance a written notice of its election to comply with the provisions of this paragraph after a specified date before January 1, 1979, which shall be the operative date of this paragraph for such insurer. However, an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no such election, the operative date of this paragraph for such insurer shall be January 1, 1979.

(i) In lieu of the mortality tables specified in this subsection, and subject to rules previously adopted by the former Department of Insurance, the insurance company may, at its option:

1. Substitute the applicable 1958 CSO or CET Smoker and Nonsmoker Mortality Tables, in lieu of the 1980 CSO or CET mortality table standard, for policies issued on or after the operative date of s. 627.476(9) and before January 1, 1989.
2. Substitute the applicable 1980 CSO or CET Smoker and Nonsmoker Mortality Tables in lieu of the 1980 CSO or CET mortality table standard;
3. Use the Annuity 2000 Mortality Table for determining the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after January 1, 1998, and before July 1, 1998.
4. Use the 1994 GAR Table for determining the minimum standard of valuation for annuities and pure endowments purchased on or after January 1, 1998, and before July 1, 1998, under group annuity and pure endowment contracts.

(j) The commission may adopt by rule the model regulation for valuation of life insurance policies as approved by the National Association of Insurance Commissioners in March 1999, including tables of select mortality factors, and may make the regulation effective for policies issued on or after January 1, 2000.

(k) For individual annuity and pure endowment contracts issued on or after July 1, 2004, excluding any disability and accidental death benefits purchased under those contracts, individual annuity mortality tables adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for those contracts.

(l) For all annuities and pure endowments purchased on or after July 1, 2004, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts, group annuity mortality tables adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for those contracts.

624.307 General powers; duties.—

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

9/10/12

M E M O R A N D U M

DATE: September 10, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for December 18, 2012
Request for Final Approval to Adopt Amendments to
Rule 69O-137.001
Annual and Quarterly Reporting Requirements
Assignment 119950-11

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before October 17, 2012 and to the Financial Services Commission on October 23, 2012, with a request for Final Approval to Adopt the proposed rule. A notice of the Final Rule Hearing will be published in the *Florida Administrative Weekly* on September 21,2012.

This rule is being amended to adopt the current versions of the National Association of Insurance Commissioner's ("NAIC") Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual.

The notice of proposed rule was published on July 20, 2012 in Volume 38, No. 29, of the *Weekly*. A hearing was held. In response to comments made at the hearing, the proposed language of Rule 69O-137.001 has been changed to adopt the most recent version of the NAIC's Actuarial Guideline 38.

Actuarial Guideline 38 deals with reserve requirements for Universal Life policies with secondary guarantees. The current version of the NAIC Accounting Practices and Procedures manuals contain an out dated version of Actuarial Guideline 38. A Notice of Change regarding the adoption of Actuarial Guideline 38 was published on September 21, 2012, in Volume 38, No. 38 of the Weekly.

The current versions of the NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual will be adopted as well.

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

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

Jason Nelson 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

M E M O R A N D U M

DATE: September 10, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill DT
Jason Nelson JN

SUBJECT: Cabinet Agenda for October 23, 2012
Request for Final Approval to Adopt Amendments to
Rule 69O-138.001
NAIC Financial Condition Handbook Adopted
Assignment 124275-12

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before October 17, 2012 and to the Financial Services Commission on October 23, 2012, with a request for Final Approval to Adopt the proposed rule. A notice of the Final Rule Hearing will be published in the *Florida Administrative Weekly* on September 21, 2012.

The notice of proposed rule was published on July 20, 2012 in Volume 38, No. 29, of the *Weekly*. A hearing was not requested, therefore, a hearing was not held

Section 624.316, Florida Statutes, requires the Office to examine insurer's financial condition using generally accepted accounting procedures. This statute also allows the Office to adopt the NAIC Financial Condition Examiners Handbook to facilitate these exams. By adopting the newest version of the handbook, this rule ensures that the procedures used by the Office to examine insurers are the current generally accepted accounting practices.

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

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

Jason Nelson 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

THE FULL TEXT OF THE PROPOSED RULE IS:

69O-137.001 Annual and Quarterly Reporting Requirements.

(1) through (3) No change

(4) Manuals Adopted.

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

1. The NAIC's Annual Statement Instructions, Property and Casualty, 2011~~2010~~;

2. The NAIC's Annual Statement Instructions, Life, Accident and Health, 2011~~2010~~;

3. The NAIC's Annual Statement Instructions, Health, 2011~~2010~~;

4. The NAIC's Annual Statement Instructions, Title, 2011~~2010~~; and

5. The NAIC's Accounting Practices and Procedures Manual, as of March 2011~~2010~~;.

(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, 2012~~2011~~;

2. The NAIC's Quarterly Statement Instructions, Life, Accident and Health, 2012~~2011~~;

3. The NAIC's Quarterly Statement Instructions, Health, 2012~~2011~~;

4. The NAIC's Quarterly Statement Instructions, Title, 2012~~2011~~; and

5. The NAIC's Accounting Practices and Procedures Manual, as of March 2012~~2011~~.

(c) no change

(5) Adoption of revised Actuarial Guideline 38.

(a) Revised NAIC Accounting Practices and Procedures Manual Actuarial Guideline 38 which appears on pages 272-285 in the agenda for the September 12, 2012 Executive (Ex) Committee and Plenary conference call at

http://www.naic.org/documents/jt_ex_plenary_120912_agenda_materials.pdf is hereby adopted and incorporated by reference and replaces the Guideline published in the Manual for annual and quarterly statements submitted to the office on and after December 31, 2012.

(b) Sections of the draft version of the Valuation Manual, adopted by NAIC Life Insurance and Annuities (A) Committee on August 17, 2012, referenced in Revised Actuarial Guideline 38 which are on pages 2-262 in the agenda for September 12, 2012 Executive (Ex) Committee and Plenary conference call at http://www.naic.org/documents/jt_ex_plenary_120912_agenda_materials.pdf are hereby adopted and incorporated by reference.

(c)Reserves reported in the 2012 annual and subsequent quarterly and annual statements to which Accounting Practices and Procedures Manual Actuarial revised Guideline 38 applies will not be based upon future versions of a draft Valuation Manual unless adopted by statute or amendment to this rule.

(d) A printed copy of the NAIC Executive (Ex) Committee and Plenary conference call agenda including attachments is available for inspection 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.

69O-138.001 NAIC Financial Condition Examiners Handbook Adopted.

(1)(a) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 2011~~(2010)~~ is hereby adopted and incorporated by reference.

(b) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 2012 ~~2011~~ is hereby adopted and incorporated by reference.

(2) – (3) No change.

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

624.308 Rules.--

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

624.424 Annual statement and other information.--

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

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

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

624.308 Rules.--

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

624.316 Examination of insurers.--

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

M E M O R A N D U M

DATE: September 7, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson JN

SUBJECT: Cabinet Agenda for December 11, 2012
Request for Final Approval to Repeal
Rule 69O-143.045
Definitions
Assignment 125254-12

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before October 17, 2012 and to the Financial Services Commission on October 23, 2012, with a request for Final Approval to Repeal Rule 69O-143.045. A notice of the Final Rule Hearing will be published in the *Florida Administrative Weekly* on September 21, 2012.

The notice of proposed rule repeal was published on July 20, 2012 in Volume 38, No. 29, of the *Weekly*. A hearing was not requested, therefore, a hearing was not held.

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

Sections 624.308, 624.307(1), 624.317, 624.318, 624.424(6), 628.251, 628.461, 628.801, 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 rule has been completed.

Jason Nelson is the attorney handling this rule. Attached are: 1) the 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-143.045 Definitions.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 624.317, 624.318, 624.424(6), 628.251, 628.461, 628.801 FS. History–New 12-16-70, Formerly 4-26.01, 4-26.001, 4-143.045, Repealed.

69O-143.045 Definitions.

As used in these rules, the following terms shall have the respective meanings hereinafter set forth, unless the context shall otherwise require:

(1) AFFILIATE. An "affiliate" of, or person "affiliated" with, a specific person; is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(2) CONTROL. The term "control" (including the terms "controlling", "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by subsection 69O-143.046(9), F.A.C., hereof that control does not exist in fact.

The Director may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(3) INSURANCE HOLDING COMPANY SYSTEM. An "insurance holding company system" consists of two or more affiliated persons, one or more of which is an insurer.

(4) INSURER. The term "insurer" shall have the same meaning as set forth in Section 624.03, F.S., except that it shall not include (1) agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state, (2) fraternal benefit societies, (3) nonprofit medical and hospital service associations, or (4) business trusts.

(5) DIRECTOR. The term "Director" shall mean the Director Office of Insurance Regulation as such is designated under or by virtue of Section 624.05, F.S., his deputies and assistants, or the Office of Insurance Regulation, as appropriate.

(6) PERSON. A "person" is an individual, a corporation, a partnership, an association, a business trust, an insurer, a company, an organization, Lloyds, a society, a reciprocal insurer or interinsurance exchange, a syndicate, an agent, a general agent, a broker, a solicitor, a service representative, an adjuster, every legal entity, a joint stock company, an unincorporated organization, any similar entity or combination acting in concert, but shall not include any securities broker performing no more than the usual and customary broker's function.

(7) SECURITYHOLDER. A "securityholder" of a specified person is one who owns any security of such person, including common stock, preferred stock, debt obligation, and any other security convertible into or evidencing the right to acquire any of the foregoing.

(8) SUBSIDIARY. A "subsidiary" of a specified person is an affiliate controlled by such person directly, or indirectly through one or more intermediaries.

(9) VOTING SECURITY. The term "voting security" shall include any security convertible into or evidencing a right to acquire a voting security.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 624.317, 624.318, 624.424(6), 628.251, 628.461, 628.801 FS. History–New 12-16-70, Formerly 4-26.01, 4-26.001, 4-143.045.

69O-143.045
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.

624.317
Investigation of agents, adjusters, administrators, service companies, and others.—If it has reason to believe that any person has violated or is violating any provision of this code, or upon the written complaint signed by any interested person indicating that any such violation may exist:
(1) The department shall conduct such investigation as it deems necessary of the accounts, records, documents, and transactions pertaining to or affecting the insurance affairs of any general agent, surplus lines agent, adjuster, managing general agent, insurance agent, insurance agency, customer representative, service representative, or other person subject to its jurisdiction, subject to the requirements of s. 626.601.
(2) The office shall conduct such investigation as it deems necessary of the accounts, records, documents, and transactions pertaining to or affecting the insurance affairs of any:
(a) Administrator, service company, or other person subject to its jurisdiction.
(b) Person having a contract or power of attorney under which she or he enjoys in fact the exclusive or dominant right to manage or control an insurer.
(c) Person engaged in or proposing to be engaged in the promotion or formation of:
1. A domestic insurer;
2. An insurance holding corporation; or
3. A corporation to finance a domestic insurer or in the production of the domestic insurer's business.

624.318 Conduct of examination or investigation; access to records; correction of accounts; appraisals.—
(1) The examination or investigation may be conducted by the accredited examiners or investigators of the department or office at the offices wherever located of the person being examined or investigated and at such other places as may be required for determination of matters under examination or investigation. In the case of alien insurers, the examination may be so conducted in the insurer's offices and places in the United States, except as otherwise required by the department or office.
(2) Every person being examined or investigated, and its officers, attorneys, employees, agents, and representatives, shall make freely available to the department or office or its examiners or investigators the accounts, records, documents, files, information, assets, and matters in their possession or control relating to the subject of the examination or investigation. An agent who provides other products or services or maintains customer information not related to insurance must maintain records relating to insurance products and transactions separately if necessary to give the department or office access to such records. If records relating to the insurance transactions are maintained by an agent on premises owned or operated by a third party, the agent and the third party must provide access to the records by the department or office.

(3) If the department or office finds any accounts or records to be inadequate, or inadequately kept or posted, it may employ experts to reconstruct, rewrite, post, or balance them at the expense of the person being examined if such person has failed to maintain, complete, or correct such records or accounting after the department or office has given her or him notice and a reasonable opportunity to do so.

(4) If the office deems it necessary to value any asset involved in such an examination of an insurer, it may make written request of the insurer to designate one or more competent appraisers acceptable to the office, who shall promptly make an appraisal of the asset and furnish a copy thereof to the office. If the insurer fails to designate such an appraiser or appraisers within 20 days after the request of the office, the office may designate the appraiser or appraisers. The reasonable expense of any such appraisal shall be a part of the expense of examination, to be borne by the insurer.

(5) Neither the department, the office, nor any examiner shall remove any record, account, document, file, or other property of the person being examined from the offices of such person except with the written consent of such person given in advance of such removal or pursuant to an order of court duly obtained.

(6) Any individual who willfully obstructs the department, the office, or the examiner in the examinations or investigations authorized by this part is guilty of a misdemeanor and upon conviction shall be punished as provided in s. 624.15.

(7)(a) The department or office or its examiners or investigators may electronically scan accounts, records, documents, files, and information, relating to the subject of the examination or investigation, in the possession or control of the person being examined or investigated.

(b) The provisions of this subsection are applicable to all investigations and examinations authorized by any provision of the Florida Insurance Code.

624.424 Annual statement and other information.—

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

628.251 Management and exclusive agency contracts.—

(1) No domestic mutual insurer or stock insurer shall make any contract whereby any person is granted or is to enjoy in fact the management of the insurer to the substantial exclusion of its board of directors or to have the controlling or preemptive right to produce substantially all insurance business for the insurer, unless the contract is filed with and approved by the office.

(2) Any such contract shall provide that any such manager or producer of its business shall within 90 days after expiration of each calendar year furnish the insurer's board of directors a written statement of amounts received under or on account of the contract and amounts expended thereunder during such calendar year, including the emoluments received therefrom by the respective directors, officers, and other principal management personnel of the manager or producer, and with such classification of items and further detail as the insurer's board of directors may reasonably require.

(3) The office shall disapprove any such contract if it finds that it:

(a) Subjects the insurer to excessive charges;

(b) Is to extend for an unreasonable length of time;

(c) Does not contain fair and adequate standards of performance; or

(d) Contains other inequitable provision or provisions which impair the proper interests of policyholders or members of the insurer.

628.461 Acquisition of controlling stock.—

(1) A person may not, individually or in conjunction with any affiliated person of such person, acquire directly or indirectly, conclude a tender offer or exchange offer for, enter into any agreement to exchange securities for, or otherwise finally acquire 5 percent or more of the outstanding voting securities of a domestic stock insurer or of a controlling company, unless:

(a) The person or affiliated person has filed with the office and sent to the insurer and controlling company a letter of notification regarding the transaction or proposed transaction no later than 5 days after any form of tender offer or exchange offer is proposed, or no later than 5 days after the acquisition of the securities if no tender offer or exchange offer is involved. The notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;

(b) The person or affiliated person has filed with the office a statement as specified in subsection (3). The statement must be completed and filed within 30 days after:

1. Any definitive acquisition agreement is entered;
2. Any form of tender offer or exchange offer is proposed; or
3. The acquisition of the securities, if no definitive acquisition agreement, tender offer, or exchange offer is involved; and

(c) The office has approved the tender or exchange offer, or acquisition if no tender offer or exchange offer is involved, and approval is in effect.

In lieu of a filing as required under this subsection, a party acquiring less than 10 percent of the outstanding voting securities of an insurer may file a disclaimer of affiliation and control. The disclaimer shall fully disclose all material relationships and basis for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation and control. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this section which may arise out of the insurer's relationship with the person unless and until the office disallows the disclaimer. The office shall disallow a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support the disallowance. A filing as required under this subsection must be made as to any acquisition that equals or exceeds 10 percent of the outstanding voting securities.

(2) This section does not apply to any acquisition of voting securities of a domestic stock insurer or of a controlling company by any person who, on July 1, 1976, is the owner of a majority of such voting securities or who, on or after July 1, 1976, becomes the owner of a majority of such voting securities with the approval of the office under this section. The person or affiliated person filing the notice required by paragraph (1)(a) may request, in writing, the office to waive the requirements of paragraph (1)(b) if there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties acquire any direct or indirect interest in the insurer. The office may waive the filing if it determines that in fact there is no change in the ultimate controlling shareholder or ownership percentages of the ultimate controlling shareholders and no unaffiliated parties will acquire any direct or indirect interest in the insurer.

(3) The statement to be filed with the office and furnished to the insurer and controlling company shall contain the following information and any additional information as the office deems necessary to determine the character, experience, ability, and other qualifications of the person or affiliated person of such person for the protection of the policyholders and shareholders of the insurer and the public:

(a) The identity of, and the background information specified in subsection (4) on, each natural person by whom, or on whose behalf, the acquisition is to be made; and, if the acquisition is to be made by, or on behalf of, a corporation, association, or trust, as to the corporation, association, or trust and as to any person who controls either directly or

indirectly the corporation, association, or trust, the identity of, and the background information specified in subsection (4) on, each director, officer, trustee, or other natural person performing duties similar to those of a director, officer, or trustee for the corporation, association, or trust;

(b) The source and amount of the funds or other consideration used, or to be used, in making the acquisition;

(c) Any plans or proposals which such persons may have made to liquidate such insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management; and any plans or proposals which such persons may have made to liquidate any controlling company of such insurer, to sell any of its assets or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management;

(d) The number of shares or other securities which the person or affiliated person of such person proposes to acquire, the terms of the proposed acquisition, and the manner in which the securities are to be acquired; and

(e) Information as to any contract, arrangement, or understanding with any party with respect to any of the securities of the insurer or controlling company, including, but not limited to, information relating to the transfer of any of the securities, option arrangements, puts or calls, or the giving or withholding of proxies, which information names the party with whom the contract, arrangement, or understanding has been entered into and gives the details thereof.

(4)(a) The information as to the background and identity of each person, which information is required to be furnished pursuant to paragraph (3)(a), shall include:

1. The person's occupations, positions of employment, and offices held during the past 10 years.

2. The principal business and address of any business, corporation, or other organization in which each such office of the person was held or in which each such occupation or position of employment was carried on.

3. Whether the person was, at any time during such 10-year period, convicted of any crime other than a traffic violation.

4. Whether the person has been, during such 10-year period, the subject of any proceeding for the revocation of any license and, if so, the nature of the proceeding and the disposition of the proceeding.

5. Whether, during the 10-year period, the person has been the subject of any proceeding under the federal [1]Bankruptcy Act or whether, during the 10-year period, any corporation, partnership, firm, trust, or association in which the person was a director, officer, trustee, partner, or other official has been subject to any such proceeding, either during the time in which the person was a director, officer, trustee, partner, or other official or within 12 months thereafter.

6. Whether, during the 10-year period, the person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law regulating the business of insurance, securities, or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities, or banking, together with details as to any such event.

(b) Any corporation, association, or trust filing the statement required by this section shall give all required information that is within the knowledge of the directors, officers, or trustees (or others performing functions similar to those of a director, officer, or trustee) of the corporation, association, or trust making the filing and of any person controlling either directly or indirectly such corporation, association, or trust. A copy of the statement and any amendments to the statement shall be sent by registered mail to the insurer at its principal office within the state and to any controlling company at its principal office. If any material change occurs in the facts set forth in the statement filed with the office and sent to such insurer or controlling company pursuant to this section, an amendment setting forth such

changes shall be filed immediately with the office and sent immediately to such insurer and controlling company.

(5)(a) The acquisition of voting securities shall be deemed approved unless the office disapproves the proposed acquisition within 90 days after the statement required by subsection (1) has been filed. The office may on its own initiate, or if requested to do so in writing by a substantially affected party shall conduct, a proceeding to consider the appropriateness of the proposed filing. The 90-day time period shall be tolled during the pendency of the proceeding. Any written request for a proceeding must be filed with the office within 10 days of the date notice of the filing is given. During the pendency of the proceeding or review period by the office, any person or affiliated person complying with the filing requirements of this section may proceed and take all steps necessary to conclude the acquisition so long as the acquisition becoming final is conditioned upon obtaining office approval. The office shall, however, at any time that it finds an immediate danger to the public health, safety, and welfare of the domestic policyholders exists, immediately order, pursuant to s. 120.569(2)(n), the proposed acquisition temporarily disapproved and any further steps to conclude the acquisition ceased.

(b) During the pendency of the office's review of any acquisition subject to the provisions of this section, the acquiring person shall not make any material change in the operation of the insurer or controlling company unless the office has specifically approved the change nor shall the acquiring person make any material change in the management of the insurer unless advance written notice of the change in management is furnished to the office. A material change in the operation of the insurer is a transaction which disposes of or obligates 5 percent or more of the capital and surplus of the insurer. A material change in the management of the insurer is any change in management involving officers or directors of the insurer or any person of the insurer or controlling company having authority to dispose of or obligate 5 percent or more of the insurer's capital or surplus. The office shall approve a material change in operation if it finds the applicable provisions of subsection (7) have been met. The office may disapprove a material change in management if it finds that the applicable provisions of subsection (7) have not been met and in such case the insurer shall promptly change management as acceptable to the office.

(c) If a request for a proceeding is filed, the proceeding shall be conducted within 60 days after the date the written request for a proceeding is received by the office. A recommended order shall be issued within 20 days of the date of the close of the proceedings. A final order shall be issued within 20 days of the date of the recommended order or, if exceptions to the recommended order are filed, within 20 days of the date the exceptions are filed.

(6) The office may disapprove any acquisition subject to the provisions of this section by any person or any affiliated person of such person who:

(a) Willfully violates this section;

(b) In violation of an order of the office issued pursuant to subsection (10), fails to divest himself or herself of any stock obtained in violation of this section, or fails to divest himself or herself of any direct or indirect control of such stock, within 25 days after such order; or

(c) In violation of an order issued by the office pursuant to subsection (10), acquires additional stock of the domestic insurance company or controlling company, or direct or indirect control of such stock, without complying with this section.

(7) The person or persons filing the statement required by subsection (1) shall have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed statement if no proceeding is conducted, that:

(a) Upon completion of the acquisition, the domestic stock insurer will be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(b) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the insurer or prejudice the interests of its policyholders or the public;

(c) Any plan or proposal which the acquiring person has, or acquiring persons have, made:
1. To liquidate the insurer, sell its assets, or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management; or
2. To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the insurer

is fair and free of prejudice to the policyholders of the domestic stock insurer or to the public;

(d) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of the domestic stock insurer indicate that the acquisition is in the best interest of the policyholders of the insurer and in the public interest;
(e) The natural persons for whom background information is required to be furnished pursuant to this section have such backgrounds as to indicate that it is in the best interests of the policyholders of the domestic stock insurer, and in the public interest, to permit such persons to exercise control over such domestic stock insurer;
(f) The officers and directors to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation;
(g) The management of the insurer after the acquisition will be competent and trustworthy and will possess sufficient managerial experience so as to make the proposed operation of the insurer not hazardous to the insurance-buying public;
(h) The management of the insurer after the acquisition will not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or otherwise acted in bad faith with respect thereto;
(i) The acquisition is not likely to be hazardous or prejudicial to the insurer's policyholders or the public; and
(j) The effect of the acquisition of control would not substantially lessen competition in insurance in this state or would not tend to create a monopoly therein.
(8) No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this section is valid. Any acquisition of any security contrary to the provisions of this section is void. Upon the petition of the domestic stock insurer or controlling company, the circuit court for the county in which the principal office of such domestic stock insurer is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the provisions of this section. There shall be a private right of action in favor of the domestic stock insurer or controlling company to enforce the provisions of this section. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the domestic stock insurer or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by such domestic stock insurer or controlling company to enforce the provisions of this section. Any person who makes or proposes an acquisition requiring the filing of a statement pursuant to this section, or who files such a statement, shall be deemed to have thereby designated the Chief Financial Officer, or his or her assistant or deputy or another person in charge of his or her office, as such person's agent for service of process under this section, and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.
(9) Any approval by the office under this section does not constitute a recommendation by the office for an acquisition, tender offer, or exchange offer. It is unlawful for a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this subsection is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this subsection is 5 years.

(10) Upon notification to the office by the domestic stock insurer or a controlling company that any person or any affiliated person of such person has acquired 5 percent or more of the outstanding voting securities of the domestic stock insurer or controlling company without complying with the provisions of this section, the office shall order that the person and any affiliated person of such person cease acquisition of any further securities of the domestic stock insurer or controlling company; however, the person or any affiliated person of such person may request a proceeding, which proceeding shall be convened within 7 days after the rendering of the order for the sole purpose of determining whether the person, individually or in connection with any affiliated person of such person, has acquired 5 percent or more of the outstanding voting securities of a domestic stock insurer or controlling company. Upon the failure of the person or affiliated person to request a hearing within 7 days, or upon a determination at a hearing convened pursuant to this subsection that the person or affiliated person has acquired voting securities of a domestic stock insurer or controlling company in violation of this section, the office may order the person and affiliated person to divest themselves of any voting securities so acquired.

(11)(a) The office shall, if necessary to protect the public interest, suspend or revoke the certificate of authority of any insurer or controlling company:

1. The control of which is acquired in violation of this section;

2. That is controlled, directly or indirectly, by any person or any affiliated person of such person who, in violation of this section, has obtained control of a domestic stock insurer or controlling company; or

3. That is controlled, directly or indirectly, by any person who, directly or indirectly, controls any other person who, in violation of this section, acquires control of a domestic stock insurer or controlling company.

(b) If any insurer is subject to suspension or revocation pursuant to paragraph (a), the insurer shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its policyholders, creditors, or stockholders or to the public.

(12)(a) For the purpose of this section, the term "affiliated person" of another person means:

1. The spouse of such other person;

2. The parents of such other person and their lineal descendants and the parents of such other person's spouse and their lineal descendants;

3. Any person who directly or indirectly owns or controls, or holds with power to vote, 5 percent or more of the outstanding voting securities of such other person;

4. Any person 5 percent or more of the outstanding voting securities of which are directly or indirectly owned or controlled, or held with power to vote, by such other person;

5. Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;

6. Any officer, director, partner, copartner, or employee of such other person;

7. If such other person is an investment company, any investment adviser of such company or any member of an advisory board of such company;

8. If such other person is an unincorporated investment company not having a board of directors, the depositor of such company; or

9. Any person who has entered into an agreement, written or unwritten, to act in concert with such other person in acquiring or limiting the disposition of securities of a domestic stock insurer or controlling company.

(b) For the purposes of this section, the term "controlling company" means any corporation, trust, or association owning, directly or indirectly, 25 percent or more of the voting securities of one or more domestic stock insurance companies.

(13) The commission may adopt, amend, or repeal rules that are necessary to implement the provisions of this section, pursuant to chapter 120.

690-143.045
Rulemaking Authority

628.801 Insurance holding companies; registration; regulation.—Every insurer that is authorized to do business in this state and that is a member of an insurance holding company shall register with the office and be subject to regulation with respect to its relationship to the holding company as provided by rule or statute. The commission shall adopt rules establishing the information and form required for registration and the manner in which registered insurers and their affiliates are regulated. The rules apply to domestic insurers, foreign insurers, and commercially domiciled insurers, except for a foreign insurer domiciled in states that are accredited by the National Association of Insurance Commissioners by December 31, 1995. Except to the extent of any conflict with this code, the rules must include all requirements and standards c ss. 4 and 5 of the Insurance Holding Company System Regulatory Act and the Insurance Holding Company System Model Regulation of the National Association of Insurance Commissioners, as the Regulatory Act a the Model Regulation existed on November 30, 2001, and may include a prohibition on oral contracts between affiliated entities. Upon request, the office may waive filing requirements under this section for a domestic insurer that is the subsidiary of an insurer that is in full compliance with the insurance holding company registration laws of its state of domicile, which state is accredited by the National Association of Insurance Commissioners.

M E M O R A N D U M

DATE: November 15, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for December 11, 2012
Request for Final Approval to Repeal
Rule 69O-157.018
Right to Return Policy-Free Look
Assignment # 126039-12

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before December 5, 2012 and to the Financial Services Commission on December 11, 2012, with a request for Final Approval to Repeal the Rule. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on October 29, 2012.

The notice of the proposed rule repeal was published on August 31, 2012 in Volume 38, No. 35, of the *Register*. A hearing was not requested, therefore, a hearing was not held.

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

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

Sections 624.308(1), 627.9407(1), 624.307(1), 627.9407(1), (7), 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 rule repeal has been completed.

Jason Nelson 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

M E M O R A N D U M

DATE: November 9, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for December 11, 2012
Request for Final Approval to Repeal
Rule 69O-185.005
Advertisement of Mortgage Insurance
Assignment #126040-12

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before December 5, 2012 and to the Financial Services Commission on December 11, 2012, with a request for Final Approval to Repeal the Rule. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on October 29, 2012.

The notice of the proposed rule repeal was published on August 31, 2012 in Volume 38, No. 35, of the *Register.* A hearing was not requested, therefore, a hearing was not held.

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

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

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

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

Jason Nelson 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

M E M O R A N D U M

DATE: November 9, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for December 11, 2012
Request for Final Approval to Repeal
Rule 69O-196.008
Failure to Comply
Assignment # 126034-12

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before December 5, 2012 and to the Financial Services Commission on December 11, 2012, with a request for Final Approval to Repeal the Rule. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on October 29, 2012.

The notice of the proposed rule repeal was published on August 31, 2012 in Volume 38, No. 35, of the *Register*. A hearing was not requested, therefore, a hearing was not held.

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

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

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

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

Jason Nelson 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

M E M O R A N D U M

DATE: November 9, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for December 11, 2012
Request for Final Approval to Repeal
Rule 69O-157.105
Refund of Premium
Assignment # 126042-12

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before December 5, 2012 and to the Financial Services Commission on December 11, 2012, with a request for Final Approval to Repeal the Rule. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on October 29, 2012.

The notice of the proposed rule repeal was published on August 31,2012 in Volume 38, No. 35, of the *Register*. A hearing was not requested, therefore, a hearing was not held.

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

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

Sections 624.308(1), 627.9701(1),(6), 627.9508,624.307(1), 627.6403, 627.6645, 627.9407, 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 rule repeal has been completed.

Jason Nelson 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

M E M O R A N D U M

DATE: September 7, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson JN

SUBJECT: Cabinet Agenda for December 11, 2012
Request for Final Approval to Repeal
Rule 69O-198.003
License Required
Assignment 125257-12

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before October 17, 2012 and to the Financial Services Commission on October 23, 2012, with a request for Final Approval to Repeal Rule 69O-198.003. A notice of the Final Rule Hearing will be published in the *Florida Administrative Weekly* on September 21, 2012.

The notice of proposed rule repeal was published on July 20, 2012 in Volume 38, No.29, of the *Weekly*. A hearing was not requested, therefore, a hearing was not held.

This rule prohibits any person, entity or administrator from providing or offering to provide service warranties unless they are authorized to do so under a license issued by the Office. This rule substantially restates the language of Section 634.403, Florida Statutes and is unnecessary. This rule should be repealed.

Sections 634.402, 634.403, 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 rule has been completed.

Jason Nelson is the attorney handling this rule. Attached are: 1) the 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

M E M O R A N D U M

DATE: September 7, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for October 23, 2012
Request for Final Approval to Repeal
Rule 69O-170.012
Sinkhole Insurance
Assignment 125252-12

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before October 17, 2012 and to the Financial Services Commission on October 23, 2012, with a request for Final Approval to Repeal Rule 69O-170.012. A notice of the Final Rule Hearing will be published in the *Florida Administrative Weekly* on September 21,2012.

The notice of proposed rule repeal was published on July 20, 2012 in Volume 38, No. 29, of the *Weekly*. A hearing was not requested, therefore, a hearing was not held.

This rule prohibits insurers from non-renewing or canceling property insurance policies "on the basis of filing of claims for partial loss caused by sinkhole damage or clay shrinkage."

This rule has become antiquated and unnecessary due to legislative changes dealing with sinkhole loss that occurred after the rule was promulgated. As a result, this rule should be repealed.

Sections 624.308(1), Sec. 4, House Bill 89-B, Special Session B (1992), Ch. 92-146, Sec.2 Laws of Florida, 624.307(1), 626.9541, 626.9641, 627.4133, 627.706 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 rule has been completed.

Jason Nelson is the attorney handling this rule. Attached are: 1) the 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-157.018 Right to Return Policy - Free Look.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.94O7(1), (7) FS. History–New 5-17-89, Formerly 4-81.018, 4-157.018, Repealed.

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

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

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

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

69O-185.005 Advertisement of Mortgage Insurance.

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

~~69O~~-185.005 Advertisement of Mortgage Insurance.

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

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

69O-196.008 Failure to Comply.

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

690-196.008 Failure to Comply.

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

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

69O-157.105 Refund of Premium.

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

69O-157.105 Refund of Premium.

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

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

69O-198.003 License Required.

Specific Authority 634.402 FS. Law Implemented 634.403. History–New 3-28-93, Formerly 4-198.003, Repealed.

69Q-198.003 License Required.

No person, entity or administrator in this state shall provide or offer to provide service warranties unless authorized therefor under a subsisting license issued by the Office.

Specific Authority 634.402 FS. Law Implemented 634.403. History–New 3-28-93, Formerly 4-198.003.

69O-170.012 Sinkhole Insurance.

Specific Authority 624.308(1) FS. Law Implemented Sec. 4, House Bill 89-B, Special Session B (1993), Ch. 92-146, Sec. 2, Laws of Florida, 624.307(1), 626.9541, 626.9641, 627.4133, 627.706 FS. History–New 9-29-92, Amended 9-8-93, Formerly 4-170.012 Repealed.

69O-170.012 Sinkhole Insurance.

(1) No insurer may nonrenew or cancel any property insurance policy "on the basis of filing of claims for partial loss caused by sinkhole damage or clay shrinkage".

(2) Subsection (1) of this rule applies regardless of whether the policy in question has been the subject of a sinkhole or clay shrinkage claim. If a sinkhole or clay shrinkage claim, or the risk associated with the occurrence of such a claim, is the basis of such contemplated cancellation or nonrenewal, subsection (1) of this rule applies. However, an insurer may nonrenew or cancel a policy if the total of claim payments for that policy exceed the current policy limits of coverage for property damage, or if the insured has failed to repair the structure in accordance with the engineering recommendations upon which any payment or policy proceeds were based.

Specific Authority 624.308(1) FS. Law Implemented Sec. 4, House Bill 89-B, Special Session B (1993), Ch. 92-146, Sec. 2, Laws of Florida, 624.307(1), 626.9541, 626.9641, 627.4133, 627.706 FS. History–New 9-29-92, Amended 9-8-93, Formerly 4-170.012.

690-157.018
Rulemaking Authority

624.308 Rules.—

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

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

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

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

624.307 General powers; duties.—

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

690-185.005
Rulemaking Authority

635.081 Administration and enforcement.—

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

635.071 Filings, approval of forms; rate filings.—

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

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

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

69O-196.008
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.

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

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

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

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

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

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

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

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

(g) A demonstrated lack of fitness or trustworthiness.

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

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

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

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

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

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

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

690-157.105
Rulemaking Authority

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

627.9407 Disclosure, advertising, and performance standards for long-term care insurance.—
(1) STANDARDS.—The commission shall adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures of the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, disclosure of tax consequences, benefit triggers, prohibition against post-claims underwriting, reporting requirements, standards for marketing, and definitions of terms.
(6) LOSS RATIO AND RESERVE STANDARDS.—The commission shall adopt rules establishing loss ratio and reserve standards for long-term care insurance policies. The rules must contain a specific reference to long-term care insurance policies. Such loss ratio and reserve standards shall be established at levels at which benefits are reasonable in relation to premiums and that provide for adequate reserving of the long-term care insurance risk.

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

627.6043 Notification of cancellation, nonrenewal, or change in rates.—
(1) Any insurer delivering or issuing an individual health insurance policy subject to this part shall give the policyholder at least 45 days' advance written notice of cancellation, nonrenewal, or a change in rates. Such notice shall be mailed to the policyholder's last address as shown by the records of the insurer. However, if cancellation is for nonpayment of premium, at least 10 days' written notice accompanied by the reason therefor shall be given. Written notice of cancellation for nonpayment of premium shall not be required for health insurance policies under which premiums are payable monthly or more frequently and regularly collected by a licensed agent.
(2) In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
(3) If the insurer fails to provide the 45 days' notice required by this section, the coverage shall remain in effect at the existing premium until 45 days after the notice is given or until the effective date of replacement coverage obtained by the insured, whichever occurs first.
627.6645 Notification of cancellation, expiration, nonrenewal, or change in rates.—
(1) Every insurer delivering or issuing for delivery a group health insurance policy under the provisions of this part shall give the policyholder at least 45 days' advance notice of cancellation, expiration, nonrenewal, or a change in rates. Such notice shall be mailed to the policyholder's last address as shown by the records of the insurer. However, if

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) PREEXISTING CONDITION.—

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

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

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

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

(5) PRIOR INSTITUTIONALIZATION.—

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

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

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

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

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

(7) RATE STRUCTURE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

627.9408 Rules.—

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

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

690-198.003
Rulemaking Authority

634.402 Powers of department, commission, and office; rules.—

The office shall administer this part, and the commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part related to service warranty associations and service warranties. The department shall administer this part and may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this part related to sales representatives. Such rules by the commission or department may identify specific methods of competition or acts or practices that are prohibited by s. 634.436, but shall not enlarge upon or extend the provisions of that section.

634.403 License required; exemptions.—

(1) No person in this state shall provide or offer to provide service warranties to residents of this state unless authorized therefor under a subsisting license issued by the office. The service warranty association shall pay to the office a license fee of $200 for such license for each license year, or part thereof, the license is in force.

(2) An insurer, while authorized to transact property or casualty insurance in this state, may also transact a service warranty business without additional qualifications or authority, but shall be otherwise subject to the applicable provisions of this part.

(3) The office may, pursuant to s. 120.569, in its discretion and without advance notice and hearing, issue an immediate final order to cease and desist to any person or entity which violates this section. The Legislature finds that a violation of this section constitutes an imminent and immediate threat to the public health, safety, and welfare of the residents of this state.

(4) Any person that is an affiliate of a domestic insurer as defined in chapter 624 is exempt from application of this part if the person does not issue, or market or cause to be marketed, service warranties to residents of this state and does not administer service warranties that were originally issued to residents of this state. The domestic insurer or its wholly owned Florida licensed insurer must be the direct obligor of all service warranties issued by such affiliate or must issue a contractual liability insurance policy to such affiliate that meets the conditions described in s. 634.406(3). If the Office of Insurance Regulation determines, after notice and opportunity for a hearing, that a person's intentional business practices do not comply with any of the exemption requirements of this subsection, the person shall be subject to this part.

(5) A person is exempt from the license requirement in this section if the person complies with the following:

(a) The service warranties are only sold to nonresidents of this state and the person does not issue, market, or cause to be marketed service warranties to residents of this state.

(b) The person submits a letter of notification that provides the following information to the office upon the start of business from this state and annually thereafter by March 1:

1. The type of products offered and a statement certifying that the products are not regulated in the state in which the person is transacting business or that the person is licensed in the state in which the person is transacting business.

2. The name of the person; the state of domicile; the home address and address in this state of the person; the names of the owners and their percentage of ownership; the names of the officers and directors; the name, e-mail, and telephone number of a contact person; the states in which the person is transacting business; and how many individuals are employed in this state.

(c) If the person ceases to do business from this state, the person shall provide written notification to the office within 30 days after cessation of business.

(6) Any person who provides, offers to provide, or holds oneself out as providing or offering to provide a service warranty to residents of this state without holding a subsisting license commits, in addition to any other violation, a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

69O-170.012
Rulemaking Authority

624.308 Rules.—

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

624.307 General powers; duties.—

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

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—

(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(a) Misrepresentations and false advertising of insurance policies.—Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:

1. Misrepresents the benefits, advantages, conditions, or terms of any insurance policy.
2. Misrepresents the dividends or share of the surplus to be received on any insurance policy.
3. Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy.
4. Is misleading, or is a misrepresentation, as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates.
5. Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof.
6. Is a misrepresentation for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.
7. Is a misrepresentation for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy.
8. Misrepresents any insurance policy as being shares of stock or misrepresents ownership interest in the company.
9. Uses any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the insurance sales activities of any person or stands behind any person's credit or that any person, the state, or the Federal Government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person.

(b) False information and advertising generally.—Knowingly making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public:

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

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

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

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

(e) False statements and entries.—

1. Knowingly:

a. Filing with any supervisory or other public official,

b. Making, publishing, disseminating, circulating,

c. Delivering to any person,

d. Placing before the public,

e. Causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public,

any false material statement.

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

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

(g) Unfair discrimination.—

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

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

3. For a health insurer, life insurer, disability insurer, property and casualty insurer, automobile insurer, or managed care provider to underwrite a policy, or refuse to issue, reissue, or renew a policy, refuse to pay a claim, cancel or otherwise terminate a policy, or increase rates based upon the fact that an insured or applicant who is also the proposed insured has made a claim or sought or should have sought medical or psychological treatment in the past for abuse, protection from abuse, or shelter from abuse, or that a claim was caused in the past by, or might occur as a result of, any future assault, battery, or sexual assault by a family or household member upon another family or household member as defined in s. 741.28. A health insurer, life insurer, disability insurer, or managed care provider may refuse to underwrite, issue, or renew a policy based on the applicant's medical condition, but shall not consider whether such condition was caused by an act of abuse. For purposes of this section, the term "abuse" means the occurrence of one or more of the following acts:

a. Attempting or committing assault, battery, sexual assault, or sexual battery;

b. Placing another in fear of imminent serious bodily injury by physical menace;

c. False imprisonment;

d. Physically or sexually abusing a minor child; or

e. An act of domestic violence as defined in s. 741.28.

This subparagraph does not prohibit a property and casualty insurer or an automobile insurer from excluding coverage for intentional acts by the insured if such exclusion does not constitute an act of unfair discrimination as defined in this paragraph.

(h) Unlawful rebates.—

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

a. Permitting, or offering to make, or making, any contract or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon;

b. Paying, allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance contract, any unlawful rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract;

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

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

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

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

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

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

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

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

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

c. No insured named in a policy, or any other person directly or indirectly connected with the transaction involving the issuance of such policy, including, but not limited to, any

This subparagraph does not prohibit a property and casualty insurer or an automobile insurer from excluding coverage for intentional acts by the insured if such exclusion does not constitute an act of unfair discrimination as defined in this paragraph.

(h) Unlawful rebates.—

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

a. Permitting, or offering to make, or making, any contract or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon;

b. Paying, allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance contract, any unlawful rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract;

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

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

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

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

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

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

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

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

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

c. No insured named in a policy, or any other person directly or indirectly connected with the transaction involving the issuance of such policy, including, but not limited to, any

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

(i) Unfair claim settlement practices.—

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) Misrepresentation in insurance applications.—

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

2. Knowingly making a material omission in the comparison of a life, health, or Medicare supplement insurance replacement policy with the policy it replaces for the purpose of

obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual. For the purposes of this subparagraph, a material omission includes the failure to advise the insured of the existence and operation of a preexisting condition clause in the replacement policy.

(l) Twisting.—Knowingly making any misleading representations or incomplete or fraudulent comparisons or fraudulent material omissions of or with respect to any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance in another insurer.

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

(n) Free insurance prohibited.—

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

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

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

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

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

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

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

c. Credit life insurance or credit disability insurance.

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

e. Title insurance.

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

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

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

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

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

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

authorized by subparagraph (q)3., in addition to the premium required by the insurer. This subparagraph shall not be construed to prohibit collection of a premium for a universal life or a variable or indeterminate value insurance policy made in accordance with the terms of the contract.

3.a. Imposing or requesting an additional premium for a policy of motor vehicle liability, personal injury protection, medical payment, or collision insurance or any combination thereof or refusing to renew the policy solely because the insured was involved in a motor vehicle accident unless the insurer's file contains information from which the insurer in good faith determines that the insured was substantially at fault in the accident.

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

(I) Lawfully parked;

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

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

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

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

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

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

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

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

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

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

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

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

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

7. No insurer may cancel or otherwise terminate any insurance contract or coverage, or require execution of a consent to rate endorsement, during the stated policy term for the

purpose of offering to issue, or issuing, a similar or identical contract or coverage to the same insured with the same exposure at a higher premium rate or continuing an existing contract or coverage with the same exposure at an increased premium.

8. No insurer may issue a nonrenewal notice on any insurance contract or coverage, or require execution of a consent to rate endorsement, for the purpose of offering to issue, or issuing, a similar or identical contract or coverage to the same insured at a higher premium rate or continuing an existing contract or coverage at an increased premium without meeting any applicable notice requirements.

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

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

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

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

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

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

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

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

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

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

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

same to be assessed and collected against such insurers; and such person so doing or performing any of such acts shall be personally liable for all such taxes.

3. A licensed agent or insurer may solicit or negotiate any insurance; seek or accept applications for insurance; issue or deliver any policy; receive, collect, or transmit premiums, to or for any insurer; or otherwise transact insurance in this state, or relative to a subject of insurance resident, located, or to be performed in this state, through the arrangement or facilities of a credit card facility or organization, for the purpose of insuring credit card holders or prospective credit card holders if:

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

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

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

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

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

5. No such insurance shall be sold through a credit card facility in conjunction with membership in any automobile club. The term "automobile club" means a legal entity which, in consideration of dues, assessments, or periodic payments of money, promises its members or subscribers to assist them in matters relating to the ownership, operation, use, or maintenance of a motor vehicle; however, the definition of automobile clubs does not include persons, associations, or corporations which are organized and operated solely for the purpose of conducting, sponsoring, or sanctioning motor vehicle races, exhibitions, or contests upon racetracks, or upon race courses established and marked as such for the duration of such particular event. The words "motor vehicle" used herein shall be the same as defined in chapter 320.

(r) Interlocking ownership and management.—

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

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

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

(s) Prohibited arrangements as to funerals.—

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

insurer. No life insurer shall designate in any life insurance policy the person to conduct the funeral of the insured as the owner of the policy.

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

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

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

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

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

2. No life insurer shall:

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

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

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

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

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

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

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

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

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

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

1. Whether or not delinquency proceedings as to the insurer have been or are to be initiated, but while such insolvency or impairment exists, no director or officer of an insurer, except with the written permission of the office, shall authorize or permit the insurer to solicit or accept new or renewal insurance risks in this state after such director or officer knew, or reasonably should have known, that the insurer was insolvent or impaired. "Impaired" includes impairment of capital or surplus, as defined in s. 631.011(12) and (13).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[1](aa) Churning.—

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

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

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

c. When the applicant is not informed that the policy values including cash values, dividends, and other assets of the existing policy or contract will be reduced, forfeited, or used in the purchase of the replacing or additional policy or contract, if this is the case; or

d. Without informing the applicant that the replacing or additional policy or contract will not be a paid-up policy or that additional premiums will be due, if this is the case.

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

2. Each insurer shall comply with sub-subparagraphs 1.c. and 1.d. by disclosing to the applicant at the time of the offer on a form designed and adopted by rule by the commission if, how, and the extent to which the policy or contract values (including cash value, dividends, and other assets) of a previously issued policy or contract will be used to purchase a replacing or additional policy or contract with the same insurer. The form must include disclosure of the premium, the death benefit of the proposed replacing or additional policy, and the date when the policy values of the existing policy or contract will be insufficient to pay the premiums of the replacing or additional policy or contract.

3. Each insurer shall adopt written procedures to reasonably avoid churning of policies or contracts that it has issued, and failure to adopt written procedures sufficient to reasonably avoid churning shall be an unfair method of competition and an unfair or deceptive act or practice.

(bb) Deceptive use of name.—Using the name or logo of a financial institution, as defined in s. 655.005(1), or its affiliates or subsidiaries when marketing or soliciting existing or prospective customers if such marketing materials are used without the written consent of the financial institution and in a manner that would lead a reasonable person to believe that the material or solicitation originated from, was endorsed by, or is related to or the responsibility of the financial institution or its affiliates or subsidiaries.

(cc) Unfair rate increases for persons in military service.—Charging an increased premium for reinstating a motor vehicle insurance policy that was canceled or suspended by the insured solely for the reason that he or she was transferred out of this state while serving in the United States Armed Forces or on active duty in the National Guard or United States Armed Forces Reserve. It is also an unfair practice for an insurer to charge an increased premium for a new motor vehicle insurance policy if the applicant for coverage or his or her covered dependents were previously insured with a different insurer and canceled that policy solely for the reason that he or she was transferred out of this state while serving in the United States Armed Forces or on active duty in the National Guard or United States Armed Forces Reserve. For purposes of determining premiums, an insurer shall consider such persons as having maintained continuous coverage.

(dd) Life insurance limitations based on past foreign travel experiences or future foreign travel plans.—

1. An insurer may not refuse life insurance to; refuse to continue the life insurance of; or limit the amount, extent, or kind of life insurance coverage available to an individual based solely on the individual's past lawful foreign travel experiences.

2. An insurer may not refuse life insurance to; refuse to continue the life insurance of; or limit the amount, extent, or kind of life insurance coverage available to an individual based solely on the individual's future lawful travel plans unless the insurer can demonstrate and the Office of Insurance Regulation determines that:

a. Individuals who travel are a separate actuarially supportable class whose risk of loss is different from those individuals who do not travel; and

b. Such risk classification is based upon sound actuarial principles and actual or reasonably anticipated experience that correlates to the risk of travel to a specific destination.

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

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

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

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

[1](ee) Fraudulent signatures on an application or policy-related document.—Willfully submitting to an insurer on behalf of a consumer an insurance application or policy-related document bearing a false or fraudulent signature.

[1](ff) Unlawful use of designations; misrepresentation of agent qualifications.—

1. A licensee may not, in any sales presentation or solicitation for insurance, use a designation or title in such a way as to falsely imply that the licensee:

a. Possesses special financial knowledge or has obtained specialized financial training; or

b. Is certified or qualified to provide specialized financial advice to senior citizens.

2. A licensee may not use terms such as "financial advisor" in such a way as to falsely imply that the licensee is licensed or qualified to discuss, sell, or recommend financial products other than insurance products.

3. A licensee may not, in any sales presentation or solicitation for insurance, falsely imply that he or she is qualified to discuss, recommend, or sell securities or other investment products in addition to insurance products.

4. A licensee who also holds a designation as a certified financial planner (CFP), chartered life underwriter (CLU), chartered financial consultant (ChFC), life underwriter training council fellow (LUTC), or the appropriate license to sell securities from the Financial Industry Regulatory Authority (FINRA) may inform the customer of those licenses or designations and make recommendations in accordance with those licenses or designations, and in so doing does not violate this paragraph.

(2) ALTERNATIVE RATES OF PAYMENT.—Nothing in this section shall be construed to prohibit an insurer or insurers from negotiating or entering into contracts with licensed health care providers for alternative rates of payment, or from limiting payments under policies pursuant to agreements with insureds, as long as the insurer offers the benefit of such alternative rates to insureds who select designated providers.

(3) INPATIENT FACILITY NETWORK.—This section may not be construed to prohibit a Medicare supplement insurer from granting a premium credit to insureds for using an in-network inpatient facility.

(4) PARTICIPATION IN A WELLNESS OR HEALTH IMPROVEMENT PROGRAM.—

(a) Authorization to offer rewards or incentives for participation.—An insurer issuing a group or individual health benefit plan may offer a voluntary wellness or health improvement program and may encourage or reward participation in the program by authorizing rewards or incentives, including, but not limited to, merchandise, gift cards, debit cards, premium discounts, contributions to a member's health savings account, or modifications to copayment, deductible, or coinsurance amounts. Any advertisement of the program is not subject to the limitations set forth in paragraph (1)(m).

(b) Verification of medical condition by nonparticipants due to medical condition.—An insurer may require a member of a health benefit plan to provide verification, such as an affirming statement from the member's physician, that the member's medical condition makes it unreasonably difficult or inadvisable to participate in the wellness or health improvement program in order for that nonparticipant to receive the reward or incentive.

(c) Disclosure requirement.—A reward or incentive offered under this subsection shall be disclosed in the policy or certificate.

(d) Other incentives.—This subsection does not prohibit insurers from offering other incentives or rewards for adherence to a wellness or health improvement program if otherwise authorized by state or federal law.

626.9641 Policyholders, bill of rights.—

(1) The principles expressed in the following statements shall serve as standards to be followed by the department, commission, and office in exercising their powers and duties, in exercising administrative discretion, in dispensing administrative interpretations of the law, and in adopting rules:

(a) Policyholders shall have the right to competitive pricing practices and marketing methods that enable them to determine the best value among comparable policies.

(b) Policyholders shall have the right to obtain comprehensive coverage.

(c) Policyholders shall have the right to insurance advertising and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy.

(d) Policyholders shall have a right to an insurance company that is financially stable.

(e) Policyholders shall have the right to be serviced by a competent, honest insurance agent or broker.

(f) Policyholders shall have the right to a readable policy.

(g) Policyholders shall have the right to an insurance company that provides an economic delivery of coverage and that tries to prevent losses.

(h) Policyholders shall have the right to a balanced and positive regulation by the department, commission, and office.

(2) This section shall not be construed as creating a civil cause of action by any individual policyholder against any individual insurer.

627.4133 Notice of cancellation, nonrenewal, or renewal premium.—

(1) Except as provided in subsection (2):

(a) An insurer issuing a policy providing coverage for workers' compensation and employer's liability insurance, property, casualty, except mortgage guaranty, surety, or marine insurance, other than motor vehicle insurance subject to s. 627.728, shall give the first-named insured at least 45 days' advance written notice of nonrenewal or of the renewal premium. If the policy is not to be renewed, the written notice shall state the reason or reasons as to why the policy is not to be renewed. This requirement applies only if the insured has furnished all of the necessary information so as to enable the insurer to develop the renewal premium prior to the expiration date of the policy to be renewed.

(b) An insurer issuing a policy providing coverage for property, casualty, except mortgage guaranty, surety, or marine insurance, other than motor vehicle insurance subject to s. 627.728 or s. 627.7281, shall give the first-named insured written notice of cancellation or termination other than nonrenewal at least 45 days prior to the effective date of the cancellation or termination, including in the written notice the reason or reasons for the cancellation or termination, except that:

1. When cancellation is for nonpayment of premium, at least 10 days' written notice of cancellation accompanied by the reason therefor shall be given. As used in this subparagraph and s. 440.42(3), the term "nonpayment of premium" means failure of the named insured to discharge when due any of her or his obligations in connection with the payment of premiums on a policy or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit, or failure to maintain membership in an organization if

such membership is a condition precedent to insurance coverage. "Nonpayment of premium" also means the failure of a financial institution to honor an insurance applicant's check after delivery to a licensed agent for payment of a premium, even if the agent has previously delivered or transferred the premium to the insurer. If a dishonored check represents the initial premium payment, the contract and all contractual obligations shall be void ab initio unless the nonpayment is cured within the earlier of 5 days after actual notice by certified mail is received by the applicant or 15 days after notice is sent to the applicant by certified mail or registered mail, and if the contract is void, any premium received by the insurer from a third party shall be refunded to that party in full; and

2. When such cancellation or termination occurs during the first 90 days during which the insurance is in force and the insurance is canceled or terminated for reasons other than nonpayment of premium, at least 20 days' written notice of cancellation or termination accompanied by the reason therefor shall be given except where there has been a material misstatement or misrepresentation or failure to comply with the underwriting requirements established by the insurer.

After the policy has been in effect for 90 days, no such policy shall be canceled by the insurer except when there has been a material misstatement, a nonpayment of premium, a failure to comply with underwriting requirements established by the insurer within 90 days of the date of effectuation of coverage, or a substantial change in the risk covered by the policy or when the cancellation is for all insureds under such policies for a given class of insureds. This subsection does not apply to individually rated risks having a policy term of less than 90 days.

(c) If an insurer fails to provide the 45-day or 20-day written notice required under this section, the coverage provided to the named insured shall remain in effect until 45 days after the notice is given or until the effective date of replacement coverage obtained by the named insured, whichever occurs first. The premium for the coverage shall remain the same during any such extension period except that, in the event of failure to provide notice of nonrenewal, if the rate filing then in effect would have resulted in a premium reduction, the premium during such extension of coverage shall be calculated based upon the later rate filing.

(2) With respect to any personal lines or commercial residential property insurance policy, including, but not limited to, any homeowner's, mobile home owner's, farmowner's, condominium association, condominium unit owner's, apartment building, or other policy covering a residential structure or its contents:

(a) The insurer shall give the first-named insured at least 45 days' advance written notice of the renewal premium.

(b) The insurer shall give the first-named insured written notice of nonrenewal, cancellation, or termination at least 100 days before the effective date of the nonrenewal, cancellation, or termination. However, the insurer shall give at least 100 days' written notice, or written notice by June 1, whichever is earlier, for any nonrenewal, cancellation, or termination that would be effective between June 1 and November 30. The notice must include the reason or reasons for the nonrenewal, cancellation, or termination, except that:

1. The insurer shall give the first-named insured written notice of nonrenewal, cancellation, or termination at least 120 days prior to the effective date of the nonrenewal, cancellation, or termination for a first-named insured whose residential structure has been insured by that insurer or an affiliated insurer for at least a 5-year period immediately prior to the date of the written notice.

2. If cancellation is for nonpayment of premium, at least 10 days' written notice of cancellation accompanied by the reason therefor must be given. As used in this subparagraph, the term "nonpayment of premium" means failure of the named insured to discharge when due her or his obligations in connection with the payment of premiums on a policy or any installment of such premium, whether the premium is payable directly to the

insurer or its agent or indirectly under any premium finance plan or extension of credit, or failure to maintain membership in an organization if such membership is a condition precedent to insurance coverage. The term also means the failure of a financial institution to honor an insurance applicant's check after delivery to a licensed agent for payment of a premium, even if the agent has previously delivered or transferred the premium to the insurer. If a dishonored check represents the initial premium payment, the contract and all contractual obligations are void ab initio unless the nonpayment is cured within the earlier of 5 days after actual notice by certified mail is received by the applicant or 15 days after notice is sent to the applicant by certified mail or registered mail, and if the contract is void, any premium received by the insurer from a third party must be refunded to that party in full.

3. If such cancellation or termination occurs during the first 90 days the insurance is in force and the insurance is canceled or terminated for reasons other than nonpayment of premium, at least 20 days' written notice of cancellation or termination accompanied by the reason therefor must be given unless there has been a material misstatement or misrepresentation or failure to comply with the underwriting requirements established by the insurer.

4. The requirement for providing written notice by June 1 of any nonrenewal that would be effective between June 1 and November 30 does not apply to the following situations, but the insurer remains subject to the requirement to provide such notice at least 100 days before the effective date of nonrenewal:

a. A policy that is nonrenewed due to a revision in the coverage for sinkhole losses and catastrophic ground cover collapse pursuant to s. 627.706.

b. A policy that is nonrenewed by Citizens Property Insurance Corporation, pursuant to s. 627.351(6), for a policy that has been assumed by an authorized insurer offering replacement coverage to the policyholder is exempt from the notice requirements of paragraph (a) and this paragraph. In such cases, the corporation must give the named insured written notice of nonrenewal at least 45 days before the effective date of the nonrenewal.

After the policy has been in effect for 90 days, the policy may not be canceled by the insurer unless there has been a material misstatement, a nonpayment of premium, a failure to comply with underwriting requirements established by the insurer within 90 days after the date of effectuation of coverage, or a substantial change in the risk covered by the policy or if the cancellation is for all insureds under such policies for a given class of insureds. This paragraph does not apply to individually rated risks having a policy term of less than 90 days.

5. Notwithstanding any other provision of law, an insurer may cancel or nonrenew a property insurance policy after at least 45 days' notice if the office finds that the early cancellation of some or all of the insurer's policies is necessary to protect the best interests of the public or policyholders and the office approves the insurer's plan for early cancellation or nonrenewal of some or all of its policies. The office may base such finding upon the financial condition of the insurer, lack of adequate reinsurance coverage for hurricane risk, or other relevant factors. The office may condition its finding on the consent of the insurer to be placed under administrative supervision pursuant to s. 624.81 or to the appointment of a receiver under chapter 631.

6. A policy covering both a home and motor vehicle may be nonrenewed for any reason applicable to either the property or motor vehicle insurance after providing 90 days' notice.

(c) If the insurer fails to provide the notice required by this subsection, other than the 10-day notice, the coverage provided to the named insured shall remain in effect until the effective date of replacement coverage or until the expiration of a period of days after the notice is given equal to the required notice period, whichever occurs first. The premium for the coverage shall remain the same during any such extension period except that, in the

event of failure to provide notice of nonrenewal, if the rate filing then in effect would have resulted in a premium reduction, the premium during such extension shall be calculated based on the later rate filing.

(d)1. Upon a declaration of an emergency pursuant to s. 252.36 and the filing of an order by the Commissioner of Insurance Regulation, an insurer may not cancel or nonrenew a personal residential or commercial residential property insurance policy covering a dwelling or residential property located in this state which has been damaged as a result of a hurricane or wind loss that is the subject of the declaration of emergency for a period of 90 days after the dwelling or residential property has been repaired. A structure is deemed to be repaired when substantially completed and restored to the extent that it is insurable by another authorized insurer that is writing policies in this state.

2. However, an insurer or agent may cancel or nonrenew such a policy prior to the repair of the dwelling or residential property:

a. Upon 10 days' notice for nonpayment of premium; or

b. Upon 45 days' notice:

(I) For a material misstatement or fraud related to the claim;

(II) If the insurer determines that the insured has unreasonably caused a delay in the repair of the dwelling; or

(III) If the insurer has paid policy limits.

3. If the insurer elects to nonrenew a policy covering a property that has been damaged, the insurer shall provide at least 90 days' notice to the insured that the insurer intends to nonrenew the policy 90 days after the dwelling or residential property has been repaired. Nothing in this paragraph shall prevent the insurer from canceling or nonrenewing the policy 90 days after the repairs are complete for the same reasons the insurer would otherwise have canceled or nonrenewed the policy but for the limitations of subparagraph 1. The Financial Services Commission may adopt rules, and the Commissioner of Insurance Regulation may issue orders, necessary to implement this paragraph.

4. This paragraph shall also apply to personal residential and commercial residential policies covering property that was damaged as the result of Tropical Storm Bonnie, Hurricane Charley, Hurricane Frances, Hurricane Ivan, or Hurricane Jeanne.

(e) If any cancellation or nonrenewal of a policy subject to this subsection is to take effect during the duration of a hurricane as defined in s. 627.4025(2)(c), the effective date of such cancellation or nonrenewal is extended until the end of the duration of such hurricane. The insurer may collect premium at the prior rates or the rates then in effect for the period of time for which coverage is extended. This paragraph does not apply to any property with respect to which replacement coverage has been obtained and which is in effect for a claim occurring during the duration of the hurricane.

(3) Claims on property insurance policies that are the result of an act of God may not be used as a cause for cancellation or nonrenewal, unless the insurer can demonstrate, by claims frequency or otherwise, that the insured has failed to take action reasonably necessary as requested by the insurer to prevent recurrence of damage to the insured property.

(4) Notwithstanding s. 440.42(3), if cancellation of a policy providing coverage for workers' compensation and employer's liability insurance is requested in writing by the insured, such cancellation shall be effective on the date requested by the insured or, if no date is specified by the insured, cancellation shall be effective on the date of the written request. The carrier is not required to send notice of cancellation to the insured if the cancellation is requested in writing by the insured. Any retroactive assumption of coverage and liabilities under a policy providing workers' compensation and employer's liability insurance may not exceed 21 days.

(5) An insurer that cancels a property insurance policy on property secured by a mortgage due to the failure of the lender to timely pay the premium when due shall reinstate the policy as required by s. 501.137.

(6) A single claim on a property insurance policy which is the result of water damage may not be used as the sole cause for cancellation or nonrenewal unless the insurer can demonstrate that the insured has failed to take action reasonably requested by the insurer to prevent a future similar occurrence of damage to the insured property.

(7)(a) Effective August 1, 2007, with respect to any residential property insurance policy, every notice of renewal premium must specify:

1. The dollar amounts recouped for assessments by the Florida Hurricane Catastrophe Fund, the Citizens Property Insurance Corporation, and the Florida Insurance Guaranty Association. The actual names of the entities must appear next to the dollar amounts.
2. The dollar amount of any premium increase that is due to an approved rate increase and the total dollar amount that is due to coverage changes.

(b) The Financial Services Commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection.

627.706 Sinkhole insurance; catastrophic ground cover collapse; definitions.—

(1)(a) Every insurer authorized to transact property insurance in this state must provide coverage for a catastrophic ground cover collapse.

(b) The insurer shall make available, for an appropriate additional premium, coverage for sinkhole losses on any structure, including the contents of personal property contained therein, to the extent provided in the form to which the coverage attaches. The insurer may require an inspection of the property before issuance of sinkhole loss coverage. A policy for residential property insurance may include a deductible amount applicable to sinkhole losses equal to 1 percent, 2 percent, 5 percent, or 10 percent of the policy dwelling limits, with appropriate premium discounts offered with each deductible amount.

(c) The insurer may restrict catastrophic ground cover collapse and sinkhole loss coverage to the principal building, as defined in the applicable policy.

(2) As used in ss. 627.706-627.7074, and as used in connection with any policy providing coverage for a catastrophic ground cover collapse or for sinkhole losses, the term:

(a) "Catastrophic ground cover collapse" means geological activity that results in all the following:

1. The abrupt collapse of the ground cover;
2. A depression in the ground cover clearly visible to the naked eye;
3. Structural damage to the covered building, including the foundation; and
4. The insured structure being condemned and ordered to be vacated by the governmental agency authorized by law to issue such an order for that structure.

Contents coverage applies if there is a loss resulting from a catastrophic ground cover collapse. Damage consisting merely of the settling or cracking of a foundation, structure, or building does not constitute a loss resulting from a catastrophic ground cover collapse.

(b) "Neutral evaluation" means the alternative dispute resolution provided in s. 627.7074.

(c) "Neutral evaluator" means a professional engineer or a professional geologist who has completed a course of study in alternative dispute resolution designed or approved by the department for use in the neutral evaluation process and who is determined by the department to be fair and impartial.

(d) "Primary structural member" means a structural element designed to provide support and stability for the vertical or lateral loads of the overall structure.

(e) "Primary structural system" means an assemblage of primary structural members.

(f) "Professional engineer" means a person, as defined in s. 471.005, who has a bachelor's degree or higher in engineering. A professional engineer must also have experience and expertise in the identification of sinkhole activity as well as other potential causes of structural damage.

(g) "Professional geologist" means a person, as defined in s. 492.102, who has a bachelor's degree or higher in geology or related earth science and experience and expertise

in the identification of sinkhole activity as well as other potential geologic causes of structural damage.

(h) "Sinkhole" means a landform created by subsidence of soil, sediment, or rock as underlying strata are dissolved by groundwater. A sinkhole forms by collapse into subterranean voids created by dissolution of limestone or dolostone or by subsidence as these strata are dissolved.

(i) "Sinkhole activity" means settlement or systematic weakening of the earth supporting the covered building only if the settlement or systematic weakening results from contemporaneous movement or raveling of soils, sediments, or rock materials into subterranean voids created by the effect of water on a limestone or similar rock formation.

(j) "Sinkhole loss" means structural damage to the covered building, including the foundation, caused by sinkhole activity. Contents coverage and additional living expenses apply only if there is structural damage to the covered building caused by sinkhole activity.

(k) "Structural damage" means a covered building, regardless of the date of its construction, has experienced the following:

1. Interior floor displacement or deflection in excess of acceptable variances as defined in ACI 117-90 or the Florida Building Code, which results in settlement-related damage to the interior such that the interior building structure or members become unfit for service or represents a safety hazard as defined within the Florida Building Code;

2. Foundation displacement or deflection in excess of acceptable variances as defined in ACI 318-95 or the Florida Building Code, which results in settlement-related damage to the primary structural members or primary structural systems that prevents those members or systems from supporting the loads and forces they were designed to support to the extent that stresses in those primary structural members or primary structural systems exceeds one and one-third the nominal strength allowed under the Florida Building Code for new buildings of similar structure, purpose, or location;

3. Damage that results in listing, leaning, or buckling of the exterior load-bearing walls or other vertical primary structural members to such an extent that a plumb line passing through the center of gravity does not fall inside the middle one-third of the base as defined within the Florida Building Code;

4. Damage that results in the building, or any portion of the building containing primary structural members or primary structural systems, being significantly likely to imminently collapse because of the movement or instability of the ground within the influence zone of the supporting ground within the sheer plane necessary for the purpose of supporting such building as defined within the Florida Building Code; or

5. Damage occurring on or after October 15, 2005, that qualifies as "substantial structural damage" as defined in the Florida Building Code.

(3) Insurers offering policies that exclude coverage for sinkhole losses must inform policyholders in bold type of not less than 14 points as follows: "YOUR POLICY PROVIDES COVERAGE FOR A CATASTROPHIC GROUND COVER COLLAPSE THAT RESULTS IN THE PROPERTY BEING CONDEMNED AND UNINHABITABLE. OTHERWISE, YOUR POLICY DOES NOT PROVIDE COVERAGE FOR SINKHOLE LOSSES. YOU MAY PURCHASE ADDITIONAL COVERAGE FOR SINKHOLE LOSSES FOR AN ADDITIONAL PREMIUM."

(4) An insurer offering sinkhole coverage to policyholders before or after the adoption of s. 30, chapter 2007-1, Laws of Florida, may nonrenew the policies of policyholders maintaining sinkhole coverage at the option of the insurer, and provide an offer of coverage that includes catastrophic ground cover collapse and excludes sinkhole coverage. Insurers acting in accordance with this subsection are subject to the following requirements:

(a) Policyholders must be notified that a nonrenewal is for purposes of removing sinkhole coverage, and that the policyholder is being offered a policy that provides coverage for catastrophic ground cover collapse.

(b) Policyholders must be provided an actuarially reasonable premium credit or discount for the removal of sinkhole coverage and provision of only catastrophic ground cover collapse.

(c) Subject to the provisions of this subsection and the insurer's approved underwriting or insurability guidelines, the insurer shall provide each policyholder with the opportunity to purchase an endorsement to his or her policy providing sinkhole coverage and may require an inspection of the property before issuance of a sinkhole coverage endorsement.

(d) Section 624.4305 does not apply to nonrenewal notices issued pursuant to this subsection.

(5) Any claim, including, but not limited to, initial, supplemental, and reopened claims under an insurance policy that provides sinkhole coverage is barred unless notice of the claim was given to the insurer in accordance with the terms of the policy within 2 years after the policyholder knew or reasonably should have known about the sinkhole loss.

Ch.92-146, Sec. 2, Laws of Florida

From the effective date of this act and through July 1, 1993, no insurer shall nonrenew any policy of property insurance on the basis of filing of claims for partial loss caused by sinkhole damage or clay shrinkage as long as the total as such payments does not exceed the current policy limits of coverage for property damage, and provided the insured has repaired the structure in accordance with the engineering recommendations upon which any payment or policy proceeds was based.

Sec. 4, House Bill 89-B, Special Session B (1983)

Section 627.707, Florida Statutes, 1992 Supplement, is amended to read:

627.707 Minimum standards for investigation of sink hole claims by insurers; nonrenewals.-

(1) Upon receipt of a claim for a sinkhole loss, and insurer must meet the following minimum standards in investigation a claim:

(a)~~(1)~~ Upon receipt of a claim for a sinkhole loss, the insurer must make an inspection of the insured's premises to determine if there has been physical damage to the structure which might be the result of sinkhole activity.

(b)~~(2)~~ If, upon the investigation pursuant to paragraph (a) ~~subsection (1)~~, the insurer discovers damage to a structure which is consistent with sinkhole activity or if the structure is located in close proximity to a structure in which sinkhole damage has been verified, then prior to denying a claim, the insurer must obtain a written certification from an individual qualified to determine the existence of sinkhole activity, stating that the cause of the claim is not sinkhole activity, and that the analysis conducted was of sufficient scope to eliminate sinkhole activity as the cause of damage within a reasonable professional probability. The written certification must also specify the professional discipline and professional licensure or registration under which the analysis was conducted. ~~Effective July 1, 1993, this section is repealed.~~

(c) If the insurer obtains, pursuant to paragraph (b), written certification that the cause of the claim was not sinkhole activity, and if the policyholder has submitted the sinkhole claim without good faith grounds for submitting such claim, the policyholder shall reimburse the insurer for 50 percent of the cost of the analysis under paragraph (b); however, a policyholder is not required to reimburse an insurer more than $2,500 with respect to any claim. A policyholder is required to pay reimbursement under this paragraph only if the insurer prior to ordering the analysis under paragraph (b), informs the policyholder of the policyholder's potential liability for reimbursement and gives the policyholder the opportunity to withdraw the claim.

(2) No insurer shall nonrenew and policy of property insurance on the basis of filing of claims fort partial loss caused by sinkhole damage or clay shrinkage as long as the total of such payments does not exceed the current policy limits of coverage for property damage, and provided the insured has repaired the structure in accordance with the engineering recommendations upon which any payment or policy proceeds was based.

690-170.012
Rulemaking Authority

M E M O R A N D U M

DATE: September 10, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill DT
Jason Nelson JN

SUBJECT: Cabinet Agenda for December 11, 2012
Request for Final Approval to Adopt Amendments to
Rule 69O-149.003
Rate Filing Procedures
Assignment 123776-12

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before October 17, 2012 and to the Financial Services Commission on October 23, 2012, with a request for Final Approval to Adopt the proposed rule. A notice of the Final Rule Hearing will be published in the *Florida Administrative Weekly* on September 21,2012.

The notice of proposed rule was published on July 20, 2012 in Volume 38, No. 29, of the *Weekly*. A hearing was held.

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

Rule 69O-149.003(5), Florida Administrative Code, allows insurers without fully credible data to make streamlined rate increase filings with the Office that are simpler in format and content than the full filing format defined in Rule 69O-149.003(2), Florida Administrative Code. Insurers who qualify and elect to file streamlined rate increase filings with the Office are limited to rate increases equal to the maximum annual medical trend for medical expense coverage or the maximum annual medical trend for Medicare Supplement coverage. The current version of Rule 69O-149.003(6), Florida Administrative Code, includes tables which display the applicable maximum annual medical trend. The proposed amendments to Rule 69O-149.003 deletes the aforementioned maximum annual medical trend tables from the text of the rule and provides the URL of the Office's website on which the Office will update the tables as needed.

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

providers with fewer than 1,000 policyholders nationwide rather than to 1,000 policyholders in Florida.

Sections 624.308(1), 624,424(1)(c), 627.410(6)(b), (e), 119.07(1)(b), 624.307(1), 626.9541(1), 627.410, 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 rule has been completed.

Jason Nelson 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-149.003 Rate Filing Procedures.

(1) – (2) – No Changes.

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

(4) No Changes.

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

(b) –(f) No changes.

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

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

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

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

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

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

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

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

690-149.003
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.

624.424 Annual statement and other information.—

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

627.410 Filing, approval of forms.—

(6) (b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof (as specified in such rule) to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 shall be for informational purposes.

(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.
1. An insurer may discontinue the availability of a policy form if the insurer provides to the office in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer shall no longer offer for sale the policy form or certificate form in this state.
2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. shall not file for approval a new policy form providing similar benefits as the discontinued form for a period of 5 years after the insurer provides notice to the office of the discontinuance. The period of discontinuance may be reduced if the office determines that a shorter period is appropriate.
3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes.

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

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

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

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—

(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(a) Misrepresentations and false advertising of insurance policies.—Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:

1. Misrepresents the benefits, advantages, conditions, or terms of any insurance policy.
2. Misrepresents the dividends or share of the surplus to be received on any insurance policy.
3. Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy.
4. Is misleading, or is a misrepresentation, as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates.
5. Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof.
6. Is a misrepresentation for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.
7. Is a misrepresentation for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy.
8. Misrepresents any insurance policy as being shares of stock or misrepresents ownership interest in the company.
9. Uses any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the insurance sales activities of any person or stands behind any person's credit or that any person, the state, or the Federal Government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person.

(b) False information and advertising generally.—Knowingly making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public:

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

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

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

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

(e) False statements and entries.—

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

any false material statement.

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

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

(g) Unfair discrimination.—

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

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

3. For a health insurer, life insurer, disability insurer, property and casualty insurer, automobile insurer, or managed care provider to underwrite a policy, or refuse to issue, reissue, or renew a policy, refuse to pay a claim, cancel or otherwise terminate a policy, or increase rates based upon the fact that an insured or applicant who is also the proposed insured has made a claim or sought or should have sought medical or psychological treatment in the past for abuse, protection from abuse, or shelter from abuse, or that a claim was caused in the past by, or might occur as a result of, any future assault, battery, or sexual assault by a family or household member upon another family or household member as defined in s. 741.28. A health insurer, life insurer, disability insurer, or managed care provider may refuse to underwrite, issue, or renew a policy based on the applicant's medical condition, but shall not consider whether such condition was caused by an act of abuse. For purposes of this section, the term "abuse" means the occurrence of one or more of the following acts:

a. Attempting or committing assault, battery, sexual assault, or sexual battery;
b. Placing another in fear of imminent serious bodily injury by physical menace;
c. False imprisonment;
d. Physically or sexually abusing a minor child; or
e. An act of domestic violence as defined in s. 741.28.

This subparagraph does not prohibit a property and casualty insurer or an automobile insurer from excluding coverage for intentional acts by the insured if such exclusion does not constitute an act of unfair discrimination as defined in this paragraph.

(h) Unlawful rebates.—

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Unfair claim settlement practices.—

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) Misrepresentation in insurance applications.—

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

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

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

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

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

(n) Free insurance prohibited.—

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

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

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

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

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

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

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

c. Credit life insurance or credit disability insurance.

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

e. Title insurance.

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

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

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

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

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

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

3.a. Imposing or requesting an additional premium for a policy of motor vehicle liability, personal injury protection, medical payment, or collision insurance or any combination

thereof or refusing to renew the policy solely because the insured was involved in a motor vehicle accident unless the insurer's file contains information from which the insurer in good faith determines that the insured was substantially at fault in the accident.

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

(I) Lawfully parked;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. No such insurance shall be sold through a credit card facility in conjunction with membership in any automobile club. The term "automobile club" means a legal entity which, in consideration of dues, assessments, or periodic payments of money, promises its members or subscribers to assist them in matters relating to the ownership, operation, use, or maintenance of a motor vehicle; however, the definition of automobile clubs does not include persons, associations, or corporations which are organized and operated solely for the purpose of conducting, sponsoring, or sanctioning motor vehicle races, exhibitions, or contests upon racetracks, or upon race courses established and marked as such for the duration of such particular event. The words "motor vehicle" used herein shall be the same as defined in chapter 320.

(r) Interlocking ownership and management.—

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

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

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

(s) Prohibited arrangements as to funerals.—

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

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

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

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

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

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

2. No life insurer shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[1](aa) Churning.—

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

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

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

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

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

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

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

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

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

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

[1](ee) Fraudulent signatures on an application or policy-related document.—Willfully submitting to an insurer on behalf of a consumer an insurance application or policy-related document bearing a false or fraudulent signature.

[1](ff) Unlawful use of designations; misrepresentation of agent qualifications.—

1. A licensee may not, in any sales presentation or solicitation for insurance, use a designation or title in such a way as to falsely imply that the licensee:

a. Possesses special financial knowledge or has obtained specialized financial training; or

b. Is certified or qualified to provide specialized financial advice to senior citizens.

2. A licensee may not use terms such as "financial advisor" in such a way as to falsely imply that the licensee is licensed or qualified to discuss, sell, or recommend financial products other than insurance products.

3. A licensee may not, in any sales presentation or solicitation for insurance, falsely imply that he or she is qualified to discuss, recommend, or sell securities or other investment products in addition to insurance products.

4. A licensee who also holds a designation as a certified financial planner (CFP), chartered life underwriter (CLU), chartered financial consultant (ChFC), life underwriter training council fellow (LUTC), or the appropriate license to sell securities from the Financial Industry Regulatory Authority (FINRA) may inform the customer of those licenses or designations and make recommendations in accordance with those licenses or designations, and in so doing does not violate this paragraph.

627.410 Filing, approval of forms.—

(1) No basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or group certificates issued under a master contract delivered in this state, or printed rider or endorsement form or form of renewal certificate, shall be delivered or issued for delivery in this state, unless the form has been filed with the office by or in behalf of the insurer which proposes to use such form and has been approved by the office. This provision does not apply to surety bonds or to policies, riders, endorsements, or forms of unique character which are designed for and used with relation to insurance upon a particular subject (other than as to health insurance), or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificateholder. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the office for information purposes only.

(2) Every such filing must be made not less than 30 days in advance of any such use or delivery. At the expiration of such 30 days, the form so filed will be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the office. The approval of any such form by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such form, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved.

(3) The office may, for cause, withdraw a previous approval. No insurer shall issue or use any form disapproved by the office, or as to which the office has withdrawn approval, after the effective date of the order of the office.

(4) The office may, by order, exempt from the requirements of this section for so long as it deems proper any insurance document or form or type thereof as specified in such order, to which, in its opinion, this section may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public.

(5) This section also applies to any such form used by domestic insurers for delivery in a jurisdiction outside this state if the insurance supervisory official of such jurisdiction informs the office that such form is not subject to approval or disapproval by such official, and upon the order of the office requiring the form to be submitted to it for the purpose. The applicable same standards apply to such forms as apply to forms for domestic use.

(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the office applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof (as specified in such rule) to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 shall be for informational purposes.

(c) Every filing made pursuant to this subsection shall be made within the same time period provided in, and shall be deemed to be approved under the same conditions as those provided in, subsection (2).

(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, shall be prohibited from applying the following rating practices:

1. Select and ultimate premium schedules.
2. Premium class definitions which classify insured based on year of issue or duration since issue.
3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.

(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form shall

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

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

2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. shall not file for approval a new policy form providing similar benefits as the discontinued form for a period of 5 years after the insurer provides notice to the office of the discontinuance. The period of discontinuance may be reduced if the office determines that a shorter period is appropriate.

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

(7)(a) Each insurer subject to the requirements of subsection (6) shall make an annual filing with the office no later than 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. The office, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(b) The filing required by this subsection shall be satisfied by one of the following methods:

1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules promulgated by the commission.

2. If no rate change is proposed, a filing which consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the commission.

(c) As used in this section, "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.

(d) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office no later than the date the filing is due.

(e) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days following the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made, until such time as the office determines that the required filing is properly submitted.

(8)(a) For the purposes of subsections (6) and (7), benefits of an individual accident and health insurance policy form, including Medicare supplement policies as defined in s. 627.672, when authorized by rules adopted by the commission, and excluding long-term care insurance policies as defined in s. 627.9404, and other policy forms under which more than 50 percent of the policies are issued to individuals age 65 and over, are deemed to be reasonable in relation to premium rates if the rates are filed pursuant to a loss ratio guarantee and both the initial rates and the durational and lifetime loss ratios have been approved by the office, and such benefits shall continue to be deemed reasonable for renewal rates while the insurer complies with such guarantee, provided the currently expected lifetime loss ratio is not more than 5 percent less than the filed lifetime loss ratio

as certified to by an actuary. The office shall have the right to bring an administrative action should it deem that the lifetime loss ratio will not be met. For Medicare supplement filings, the office may withdraw a previously approved filing which was made pursuant to a loss ratio guarantee if it determines that the filing is not in compliance with ss. 627.671-627.675 or the currently expected lifetime loss ratio is less than the filed lifetime loss ratio as certified by an actuary in the initial guaranteed loss ratio filing. If this section conflicts with ss. 627.671-627.675, ss. 627.671-627.675 shall control.

(b) The renewal premium rates shall be deemed to be approved upon filing with the office if the filing is accompanied by the most current approved loss ratio guarantee. The loss ratio guarantee shall be in writing, shall be signed by an officer of the insurer, and shall contain at least:

1. A recitation of the anticipated lifetime and durational target loss ratios contained in the actuarial memorandum filed with the policy form when it was originally approved. The durational target loss ratios shall be calculated for 1-year experience periods. If statutory changes have rendered any portion of such actuarial memorandum obsolete, the loss ratio guarantee shall also include an amendment to the actuarial memorandum reflecting current law and containing new lifetime and durational loss ratio targets.

2. A guarantee that the applicable loss ratios for the experience period in which the new rates will take effect, and for each experience period thereafter until new rates are filed, will meet the loss ratios referred to in subparagraph 1.

3. A guarantee that the applicable loss ratio results for the experience period will be independently audited at the insurer's expense. The audit shall be performed in the second calendar quarter of the year following the end of the experience period, and the audited results shall be reported to the office no later than the end of such quarter. The commission shall establish by rule the minimum information reasonably necessary to be included in the report. The audit shall be done in accordance with accepted accounting and actuarial principles.

4. A guarantee that affected policyholders in this state shall be issued a proportional refund, based on the premium earned, of the amount necessary to bring the applicable experience period loss ratio up to the durational target loss ratio referred to in subparagraph 1. The refund shall be made to all policyholders in this state who are insured under the applicable policy form as of the last day of the experience period, except that no refund need be made to a policyholder in an amount less than $10. Refunds less than $10 shall be aggregated and paid pro rata to the policyholders receiving refunds. The refund shall include interest at the then-current variable loan interest rate for life insurance policies established by the National Association of Insurance Commissioners, from the end of the experience period until the date of payment. Payments shall be made during the third calendar quarter of the year following the experience period for which a refund is determined to be due. However, no refunds shall be made until 60 days after the filing of the audit report in order that the office has adequate time to review the report.

5. A guarantee that if the applicable loss ratio exceeds the durational target loss ratio for that experience period by more than 20 percent, provided there are at least 2,000 policyholders on the form nationwide or, if not, then accumulated each calendar year until 2,000 policyholder years is reached, the insurer, if directed by the office, shall withdraw the policy form for the purposes of issuing new policies.

(c) As used in this subsection:

1. "Loss ratio" means the ratio of incurred claims to earned premium.

2. "Applicable loss ratio" means the loss ratio attributable solely to this state if there are 2,000 or more policyholders in the state. If there are 500 or more policyholders in this state but less than 2,000, it is the linear interpolation of the nationwide loss ratio and the loss ratio for this state. If there are less than 500 policyholders in this state, it is the nationwide loss ratio.

3. "Experience period" means the period, ordinarily a calendar year, for which a loss ratio guarantee is calculated.

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M E M O R A N D U M

DATE: September 20, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for December 11, 2012
Request for Final Approval to Adopt Amendments to
Rule 69O-149.022
Forms Adopted
Assignment 124691-12

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before October 17, 2012 and to the Financial Services Commission on October 23, 2012, with a request for Final Approval to Adopt the proposed rules. A notice of the Commission Final Rule Hearing will be published in the *Florida Administrative Weekly* on September 21, 2012.

The notice of proposed rules was published July 20, 2012 in Volume 38, No. 29, of the *Weekly*. A hearing was held. There has been one change to the forms published on September 28, 2012 in Volume 38, No. 39, of the *Weekly*.

Form OIR-B2-1507 "Universal Standardized Data Letter" and OIR-B2-1505A "Instruction Sheet" are being revised to provide for more efficient generation of data processing for review by the Office of form and rate filings submitted by insurers. The definitions used in the instructions are being updated and made consistent with the changes to the form.

Sections 624.308, 624.424(1)(c), 627.410, 636.216, 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-149.022 Forms Adopted.

(1) The forms adopted in subsection (2), below, shall be used, as applicable, by insurers making form filings for life and accident insurance, annuities, and health insurance. All the forms in subsection (2), below, are hereby adopted and incorporated by reference. All forms are available and may be printed from the Office's website: www.floir.com.

(2)(a) Form OIR-B2-1507, "Office of Insurance Regulation, Life and Health Forms and Rates Universal Standardized Data Letter", Rev. ~~9/04~~ 06/12.

(b) Form OIR-B2-1507 A, "Office of Insurance Regulation, Life and Health Forms and Rates Universal Standardized Data Letter Instruction Sheet", Rev. ~~9/04~~ 06/12.

(c) No Change

(d) No Change

Specific Authority 624.308 FS. Law Implemented 624.424(1)(c), 627.410, 636.216 FS. History–New 10-29-91, Amended 5-15-96, 4-4-02, 5-2-02, 6-19-03, Formerly 4-149.022, Amended 4-7-05, 1-12-06.

69O-149.022
Rulemaking Authority

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.424 Annual statement and other information.—

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

627.410 Filing, approval of forms.—
(1) No basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or group certificates issued under a master contract delivered in this state, or printed rider or endorsement form or form of renewal certificate, shall be delivered or issued for delivery in this state, unless the form has been filed with the office by or in behalf of the insurer which proposes to use such form and has been approved by the office. This provision does not apply to surety bonds or to policies, riders, endorsements, or forms of unique character which are designed for and used with relation to insurance upon a particular subject (other than as to health insurance), or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificateholder. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the office for information purposes only.
(2) Every such filing must be made not less than 30 days in advance of any such use or delivery. At the expiration of such 30 days, the form so filed will be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the office. The approval of any such form by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such form, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved.
(3) The office may, for cause, withdraw a previous approval. No insurer shall issue or use any form disapproved by the office, or as to which the office has withdrawn approval, after the effective date of the order of the office.
(4) The office may, by order, exempt from the requirements of this section for so long as it deems proper any insurance document or form or type thereof as specified in such order, to which, in its opinion, this section may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public.
(5) This section also applies to any such form used by domestic insurers for delivery in a jurisdiction outside this state if the insurance supervisory official of such jurisdiction informs the office that such form is not subject to approval or disapproval by such official, and upon the order of the office requiring the form to be submitted to it for the purpose. The applicable same standards apply to such forms as apply to forms for domestic use.
(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating

manuals and rating schedules are not applicable, the insurer must file with the office applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof (as specified in such rule) to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 shall be for informational purposes.

(c) Every filing made pursuant to this subsection shall be made within the same time period provided in, and shall be deemed to be approved under the same conditions as those provided in, subsection (2).

(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, shall be prohibited from applying the following rating practices:

1. Select and ultimate premium schedules.

2. Premium class definitions which classify insured based on year of issue or duration since issue.

3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.

(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.

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

2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. shall not file for approval a new policy form providing similar benefits as the discontinued form for a period of 5 years after the insurer provides notice to the office of the discontinuance. The period of discontinuance may be reduced if the office determines that a shorter period is appropriate.

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

(7)(a) Each insurer subject to the requirements of subsection (6) shall make an annual filing with the office no later than 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. The office, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(b) The filing required by this subsection shall be satisfied by one of the following methods:

1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules promulgated by the commission.

2. If no rate change is proposed, a filing which consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the commission.

(c) As used in this section, "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.

(d) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office no later than the date the filing is due.

(e) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days following the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made, until such time as the office determines that the required filing is properly submitted.

(8)(a) For the purposes of subsections (6) and (7), benefits of an individual accident and health insurance policy form, including Medicare supplement policies as defined in s. 627.672, when authorized by rules adopted by the commission, and excluding long-term care insurance policies as defined in s. 627.9404, and other policy forms under which more than 50 percent of the policies are issued to individuals age 65 and over, are deemed to be reasonable in relation to premium rates if the rates are filed pursuant to a loss ratio guarantee and both the initial rates and the durational and lifetime loss ratios have been approved by the office, and such benefits shall continue to be deemed reasonable for renewal rates while the insurer complies with such guarantee, provided the currently expected lifetime loss ratio is not more than 5 percent less than the filed lifetime loss ratio as certified to by an actuary. The office shall have the right to bring an administrative action should it deem that the lifetime loss ratio will not be met. For Medicare supplement filings, the office may withdraw a previously approved filing which was made pursuant to a loss ratio guarantee if it determines that the filing is not in compliance with ss. 627.671-627.675 or the currently expected lifetime loss ratio is less than the filed lifetime loss ratio as certified by an actuary in the initial guaranteed loss ratio filing. If this section conflicts with ss. 627.671-627.675, ss. 627.671-627.675 shall control.

(b) The renewal premium rates shall be deemed to be approved upon filing with the office if the filing is accompanied by the most current approved loss ratio guarantee. The loss ratio guarantee shall be in writing, shall be signed by an officer of the insurer, and shall contain at least:

1. A recitation of the anticipated lifetime and durational target loss ratios contained in the actuarial memorandum filed with the policy form when it was originally approved. The durational target loss ratios shall be calculated for 1-year experience periods. If statutory changes have rendered any portion of such actuarial memorandum obsolete, the loss ratio guarantee shall also include an amendment to the actuarial memorandum reflecting current law and containing new lifetime and durational loss ratio targets.

2. A guarantee that the applicable loss ratios for the experience period in which the new rates will take effect, and for each experience period thereafter until new rates are filed, will meet the loss ratios referred to in subparagraph 1.

3. A guarantee that the applicable loss ratio results for the experience period will be independently audited at the insurer's expense. The audit shall be performed in the second calendar quarter of the year following the end of the experience period, and the audited results shall be reported to the office no later than the end of such quarter. The commission

shall establish by rule the minimum information reasonably necessary to be included in the report. The audit shall be done in accordance with accepted accounting and actuarial principles.

4. A guarantee that affected policyholders in this state shall be issued a proportional refund, based on the premium earned, of the amount necessary to bring the applicable experience period loss ratio up to the durational target loss ratio referred to in subparagraph 1. The refund shall be made to all policyholders in this state who are insured under the applicable policy form as of the last day of the experience period, except that no refund need be made to a policyholder in an amount less than $10. Refunds less than $10 shall be aggregated and paid pro rata to the policyholders receiving refunds. The refund shall include interest at the then-current variable loan interest rate for life insurance policies established by the National Association of Insurance Commissioners, from the end of the experience period until the date of payment. Payments shall be made during the third calendar quarter of the year following the experience period for which a refund is determined to be due. However, no refunds shall be made until 60 days after the filing of the audit report in order that the office has adequate time to review the report.

5. A guarantee that if the applicable loss ratio exceeds the durational target loss ratio for that experience period by more than 20 percent, provided there are at least 2,000 policyholders on the form nationwide or, if not, then accumulated each calendar year until 2,000 policyholder years is reached, the insurer, if directed by the office, shall withdraw the policy form for the purposes of issuing new policies.

(c) As used in this subsection:

1. "Loss ratio" means the ratio of incurred claims to earned premium.

2. "Applicable loss ratio" means the loss ratio attributable solely to this state if there are 2,000 or more policyholders in the state. If there are 500 or more policyholders in this state but less than 2,000, it is the linear interpolation of the nationwide loss ratio and the loss ratio for this state. If there are less than 500 policyholders in this state, it is the nationwide loss ratio.

3. "Experience period" means the period, ordinarily a calendar year, for which a loss ratio guarantee is calculated.

636.216 Charge or form filings.—

(1) All charges to members must be filed with the office and any charge to members greater than $30 per month or $360 per year must be approved by the office before the charges can be used. The discount medical plan organization has the burden of proof that the charges bear a reasonable relation to the benefits received by the member.

(2) There must be a written agreement between the discount medical plan organization and the member specifying the benefits under the discount medical plan and complying with the disclosure requirements of this part.

(3) All forms used, including the written agreement pursuant to subsection (2), must first be filed with and approved by the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form.

(4) A charge or form is considered approved on the 60th day after its date of filing unless it has been previously disapproved by the office. The office shall disapprove any form that does not meet the requirements of this part or that is unreasonable, discriminatory, misleading, or unfair. If such filings are disapproved, the office shall notify the discount medical plan organization and shall specify in the notice the reasons for disapproval.

UNIVERSAL STANDARDIZED DATA LETTER INSTRUCTIONS

Only one Universal Standardized Data Letter (UDL) may be provided in each filing. Revised UDLs may be submitted to correct information and will replace any previous submissions within the same filing.

Section I. Instructions and Information

Section II. Contact Information: Provide the requested contact information for both the filing originator and the company contact. Select the preferred email address to be used for all correspondence. Provide additional email addresses to be copied on all correspondence, separated by a semi-colon. This section must be filled out for all filings.

Section III. General Information: This section must be filled out for all filings.

Section IV. Life & Health Insurance: Select the applicable filing and product characteristics.

Section IV.C. Group Policy Characteristics:

	Life groups defined in:	**Health** groups defined in:
Employee Groups	Section 627.552, F.S.	Section 627.653, F.S.
Labor Union Groups	Section 627.554, F.S.	Section 627.654, F.S.
Debtor Groups	Section 627.553, F.S.	Section 627.655, F.S.
Association Groups	Section 627.5567, F.S.	Section 627.654, F.S.
Additional Groups	Section 627.5565, F.S.	Section 627.656, F.S.
Blanket Health Insurance	not applicable	Section 627.659, F.S.
Franchise Health Insurance	not applicable	Section 627.663, F.S.

Section IV.D. Individual Policy Characteristics:

Optionally Renewable:
Renewal can be declined on any individual or group contract at the option of the insurer.

Conditionally Renewable:
Renewal can be declined by class, by geographic area or for stated reasons other than the deterioration of health. The insurer may revise rates on a class basis.

Guaranteed Renewable:
Renewal cannot be declined by the insurer for any reason other than fraud, misrepresentation, failure to pay the premium when due, or expiration of the contract, but the insurer can revise rates on a class basis. (See also Sections 627.6425 & 627.6571, F.S.)

Non-Cancelable:
Renewal cannot be declined for any reason other than fraud, misrepresentation, or failure to pay the premium when due, and that rates cannot be revised by the insurer.

Non-Renewable:
A contractual provision exists which prevents a policy duration of more than a specific period, which shall be no more than one year.

Section V. Rate Filing History – Including Annual Rate Certifications

This section is for Florida experience only and reflects aggregate data. Please provide the information for the current filing and the two most recent rate filings that were either approved or acknowledged, if applicable. For filings submitted on or after the effective date of this form, the data for columns (5) and (7) is not required to be filled in for the two prior filings unless available. Beginning one year following the effective date of this form, the data must be filled in for the first prior filing. Beginning two years following the effective date of this form, the data must be filled in for both prior filings.

(1) Average Rate Change Requested - The percentage increase in the average annualized premium being requested. The average annualized premium should be calculated on the basis of the inforce distribution. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.* Not applicable to the current filing; requested rate change for current filing is in column (4).

(2) Total Annualized Premium Volume - Total premium volume, on an annualized premium basis, for the inforce

policies at the valuation date for the related filing.

(3) Number of Group Certificates or Individual Policies - For group coverage, provide the number of certificates/subscribers in force at the valuation date for the related filing. For individual coverage, provide the number of policies at the valuation date for the related filing. The total count should be provided, and should include policies with no premium. Policies in a delinquent status should be included.

(4) Average Rate Change - The average rate revision requested, or for prior filings, the average rate revision approved, expressed as the percentage increase in the average annual premium. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.*

(5) Minimum Rate Change – The smallest increase (this may be a negative number) due to the filing affecting any specific individual policyholder or group certificateholder. For the current filing, this is the requested value. For any prior filings, this is the approved value. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.*

(6) Maximum Rate Change - The largest increase (this may be a negative number) due to the filing affecting any specific individual policyholder or group certificateholder. For the current filing, this is the requested value. For any prior filings, this is the approved value. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.*

(7) Average Benefit Change – The average benefit revision requested, or for prior filings, the average benefit revision approved, expressed as a percentage increase in the benefit schedule. Benefit changes due to changes in duration or aging should not be included.

(8) Date Change Approved or Acknowledged - The date the prior filing was closed. Not applicable to the current filing. Dates must be in mm/dd/yyyy format.

(9) Florida Filing Number – The Florida file log number (ex: 11-12345) which identifies the filing. File log numbers must be in ##-##### format without text. Not applicable to the current filing.

(10) Effective Date of Change – For the current filing, provide the target effective date of the requested rate and/or benefit change. For prior filings, provide the effective date of the approved rate and/or benefit change. Not applicable for filings with no rate or benefit changes. Dates must be in mm/dd/yyyy format.

Section VI. Rate Request By Form – Including New Form Submissions - To be completed for all rate filings. This is all filings that involve a rates section review (ex. Rate Only filings, Forms and Rates filings, ARC filings).

This section is for Florida experience only. Each form included in the filing must be listed individually. Additional form rows may be added. Forms such as applications and outlines of coverage do not need to be listed. This section is intended to capture forms such as policies, certificates, riders, and endorsements. Each form in a series must be listed separately. If the premium or claims for a base policy and a rider cannot be separated, the rider should still be included in this section and the number of individual policyholders or group certificateholders should be provided.

(1) Form Number - The form number of the form being filed. Only one form number should be listed in each row. Riders and endorsements should be included and listed individually separately from the base form. The form number should exactly match the form number on the form; all special characters, spaces, and letters must be included.

(2) Base Form or Rider – Indicate if the form listed is a base form or a rider. For the purposes of this form, endorsements may be considered riders as they are not stand-alone forms.

(3) Marketing Product Name (Street Name) – The name used to market or advertise the form. This is not the form number. Leave blank if not available or known. This field is not required for forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994.

(4) Average Rate Change Requested - The requested percentage increase in the average annual premium for only the applicable form. The average annual premium should be calculated on the basis of the inforce distribution. 0.0% for new forms and annual rate certification filings. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.*

(5) Minimum Rate Change Requested - The smallest requested increase (this may be a negative number) affecting any specific individual policyholder or group certificateholder on only the applicable form. 0.0% for new forms and annual rate certification filings. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.*

(6) Maximum Rate Change Requested - The largest requested increase (this may be a negative number) affecting any specific individual policyholder or group certificateholder on only the applicable form. 0.0% for new forms and annual rate certification filings. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.*

(7) Average Benefit Change Requested - The average benefit revision requested on only the applicable form expressed as a percentage increase in the benefit schedule. Benefit changes due to changes in duration or aging should not be included. 0.0% for new forms and annual rate certification filings.

(8) Total Annualized Premium Volume - Total premium volume, on an annualized premium basis, for the inforce policies at the valuation date for the filing for only the applicable form.

(9) Total Incurred Claims – Total amount of claims occurring in the twelve months prior to the valuation date for the filing, whether or not paid during that time, for only the applicable form. This field is not required for forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994. If an exact amount is unavailable, provide an estimate for the twelve month period.

(10) Number of Group Certificates or Individual Policies - For group coverage, provide the number of certificates in force, for only the applicable form, at the valuation date for the filing. For individual coverage, provide the number of policies, for only the applicable form, at the valuation date for the related filing. The total count should be provided, and should include policies with no premium. Policies in a delinquent status should be included. For filings including base and rider forms, the sum of these fields may not equal the total fields in section V and VII because insureds with selected riders will be counted multiple times.

(11) Number of Covered Dependents/Additional Lives – The total number of dependents, excluding primary insureds, and/or the total number of additional lives (ex: for joint coverage with two primary insureds, there is one additional life). This field is not required for forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994. If an exact number is unavailable, provide an estimate.

(12) Number of Covered Lives – Automatically calculated as column (10) plus column (11).

(13) Inception Date or New Form – Provide the date the form was approved or indicate that the form is new. A form is new if it has never been approved by the Office. Dates must be in mm/dd/yyyy format. If the exact date is unknown, a date should be estimated. If only the year is known, enter 01/01 with the estimated year.

(14) Discontinued Date – Provide the date the form was closed to new sales. Leave blank if the form is currently available for sale. Dates must be in mm/dd/yyyy format. If the exact date is unknown, a date should be estimated. If only the year is known, enter 01/01 with the estimated year.

(15) Number of Member Months – Applies to Major Medical coverage only. This field is not required for forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994.

(16) Major Medical Coverage Type – Select all applicable coverage types. Applies to Major Medical coverage only. This field is not required for forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994.

For Major Medical Forms Only, complete the large claims table. There should be only one claim per row. A claim is counted as the first incidence or diagnosis of an event resulting in a covered benefit or series of covered benefits. If an insured has had more than one large claim in a calendar year, the claims should be listed on multiple rows. Additional rows may be added. For small group coverage, exclude claims for 1-life groups.

(1) Amount – Provide the dollar amount of the incurred claim. Please enter only one claim per row.

(2) Incurral Year – Provide the calendar year in which the claim was incurred in YYYY format.

Section VII. Additional Data For All Rate Filings - To be completed for all rate filings. This is all filings that involve a rates section review (ex. Rate Only filings, Forms and Rates filings, ARC filings).

This section reflects aggregate data for both Florida and Nationwide. Provide current data for the form(s) included in the filing which are listed in section VI. If there is no experience outside of Florida, the nationwide section should be identical to the Florida section. If Florida experience is fully credible, as demonstrated in the filing, then the nationwide loss ratio fields (F, G, H, I, J) and nationwide actual-to-expected loss ratio fields (K, L, M) are not required to be completed. If the company is filing for an annual rate filing exemption on a closed block or if the block includes only forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994, the Florida and nationwide loss ratio fields (F, G, H, I, J) and actual-to-expected loss ratio fields (K, L, M) are not required to be completed. All requests for permanent exemption must provide the experience data necessary to demonstrate compliance with the requirements of Rule 69O-149, F.A.C.

A. Number of Group Certificates or Individual Policies - For group coverage, provide the number of individual certificates or subscribers in force. For individual coverage, provide the number of policies. The total count should be provided, and should include policies with no premium. Policies in a delinquent status should be included.

B. Average Number of Certificates Per Policy – Applies only to group coverage. (A ÷ B should yield the number of groups)

C. Total Annualized Premium Volume - Premium volume, on an annualized premium basis, for the current inforce policies at the valuation date for the filing. The prior amount reflects the annualized premium before any rate changes. The projected amount reflects the projected annualized premium twelve months following the effective date for the filing, or a twelve month basis consistent with the company's premium data, taking into consideration lapses (if applicable) and any proposed rate changes, but assumes no new issues. The prior value should equal the sum of column (8) in section VI.

D. Total Incurred Claims - Total dollar amount of claims occurring in a year, whether or not paid during that year. The prior amount reflects the twelve months prior to the valuation date for the filing. The projected amount reflects the twelve months following the effective date for the filing, or a twelve month basis consistent with the company's claim data, taking into consideration lapses (if applicable) and any proposed benefit changes, but assumes no new issues. The prior value should equal the sum of column (9) in section VI. This field is not required if the block includes only forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994.

E. Average Annual Premium - The average annualized premium based on the inforce distribution of policies. The current value should reflect the current average annual premium with no changes. The proposed value should reflect the current value including proposed changes to base premiums; excluding only trend that is implemented more frequently than once in twelve months.* For new forms, a value should be provided in the proposed field.

F. Anticipated Loss Ratio – The present value of future claims, divided by the present value of future earned premiums. The current value should assume no rate and/or benefit changes. The proposed value should reflect the proposed rate and/or benefit changes. For new forms, a value should be provided in the proposed field.

G. Lifetime Loss Ratio – The present value of incurred claims, past and future, divided by the present value of earned premiums, past and future. The current value should assume no rate and/or benefit changes. The proposed value should reflect the proposed rate and/or benefit changes. For new forms, a value should be provided in the proposed field.

H. Target Loss Ratio – The originally filed lifetime loss ratio standard for the form, established at pricing or revised and approved by the Office, and should be equivalent to the present value of the durational loss ratio curve. Applies to both individual and group coverage. This is not the minimum loss ratio established in Rule. For annually rated group products, this is the expected or anticipated loss ratio. For pooled blocks, this is the weighted average by form and/or group size. For new forms, a value is required.

I. Total Past Incurred Loss Ratio Without Active Life Reserve Increases – The accumulated value of past incurred claims divided by the accumulated value of the past earned premiums.

J. Latest Calendar Year Loss Ratio for Policies 3 Years and Older (for Medicare Supplement) without Policy Reserves – The loss ratio, for the most recently completed calendar year for those policies or certificates which have been in force for 3 or more years.

K. Anticipated Actual-to-Expected Loss Ratio – The ratio of the actual anticipated loss ratio divided by the future expected loss ratio. This is equivalent to the present value of the projected incurred claims divided by the present value of the future expected incurred claims.

L. Lifetime Actual-to-Expected Loss Ratio – The ratio of the actual lifetime loss ratio divided by the lifetime expected loss ratio. This is equivalent to the present value of the past and projected incurred claims divided by the present value of the past and future expected incurred claims.

M. Total Past Actual-to-Expected Loss Ratio – The ratio of the actual past loss ratio divided by the past expected loss ratio. This is equivalent to the present value of the past incurred claims divided by the present value of the past expected incurred claims.

N. Valuation Date of Data – The point in time at which the data was determined. This date separates the past and future experience.

Section VIII. Rate Filing Certification - A qualified actuary, an officer of the company, or a designated compliance person must certify to the rate information provided.

Section IX. Readability Certification – An officer of the company must certify as to the readability of the forms.

Section X. Checklist Certification – An officer of the company or a designated compliance person must certify that all the information provided is correct.

Section XI. Forms To Be Reviewed

Form Title - The name of the form, for example "Application for Base Form ABC-FL." If submitting a form, this field is required.

Form number - The form number present on the form being submitted in the filing. If submitting a form, this field is required.

Original Filing Number – The Florida file log number of the filing in which the original form was filed and approved. File log numbers must be in ##-##### format without text.

Original Form Number - The number of the form, which will be discontinued for future sales, that is being replaced, if applicable.

Data that is not required per these instructions may be requested by the Office if such information is necessary for a proper review of the filing. In the event of conflict in the definitions in these instructions, the definitions in Florida Statute and Rule shall prevail.

If a field is not applicable, leave the field blank.

** Trend implemented more frequently than once in twelve months is not included. Although this value is not captured in this form, it must be reported in the actuarial memorandum, the factors and associated dates must be in the rate manual, and the value must be taken into account in all appropriate exhibits, loss ratio calculations, and actual-to-expected calculations.*

For example: The currently approved base rate is $100. The company requests 9% trend to be implemented quarterly. The rate on the effective date of the filing is $100 for the first quarter, $102.18 for the second quarter, $104.40 for the third quarter, $106.68 for the fourth quarter, and the next filing will begin with a rate of $109.

Trend implemented once per year, which does not raise the rates in intervals as the year progresses, is included.

For example: The currently approved base rate is $100 and will not be trended throughout the year. In the next filing, the company requests a 9% increase due to trend. The rate on the effective date of the filing is $109 and will not change throughout the year. The next filing will begin with a rate of $109. This is the same effect as approving a 9% base rate increase; therefore, trend implemented once per year is included in the all of the requested rate change fields.

Note that trend must be requested, justified, and approved before being implemented. Upon approval, the trend, regardless of

how frequently it is implemented, is reflected in the anniversary rate change reported in the filing. Trend is approved for up to twelve months, after which the rates may not change without approval from the Office.

DEPARTMENT OF FINANCIAL SERVICES

Office of Insurance Regulation – Bureau of Life & Health Forms and Rates

UNIVERSAL STANDARDIZED DATA LETTER

What is the purpose of this filing?

(Check one)

- ☐ Forms Only
- ☐ Forms & Rates
- ☐ Rates Only
- ☐ Annual Rate Certification (no rate or benefit changes)

Company Information:

FEIN _____ NAIC Company Code _____

Company Name _____

SECTION I. INSTRUCTIONS AND INFORMATION

This online form must accompany all Life & Health Form or Rate filings submitted to the Office. If you have questions regarding the information requested, please consult our website at www.floir.com or contact us at (850) 413-3152.

SECTION II. CONTACT INFORMATION

Preferred Email Address: (for all correspondence)
- ☐ I-Portal Account Email
- ☐ Filing Originator Email
- ☐ Company Contact Email
- ☐ Other

Additional Email Addresses: _____

Filing Originator Information

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Contact Name: _____ Contact Title: _____

Professional Designation: _____ Contact Email: _____

Street Address: _____ Suite/Room #: _____

P.O. Box Mailing Address: _____

DEPARTMENT OF FINANCIAL SERVICES

Office of Insurance Regulation – Bureau of Life & Health Forms and Rates

UNIVERSAL STANDARDIZED DATA LETTER

Department:

City: State: Zip Code: -

Country: Non US Postal Code:

Phone Number: Ext Fax Number:

Toll Free Number: Ext Non US Phone Number:

Company Contact Information

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Contact Name: Contact Title:

Professional Designation: Contact Email:

Street Address: Suite/Room #:

P.O. Box Mailing Address:

Department:

City: State: Zip Code: -

Country: Non US Postal Code:

Phone Number: Ext Fax Number:

Toll Free Number: Ext Non US Phone Number:

SECTION III. GENERAL INFORMATION

A. Do you currently have in force business on this plan of insurance in Florida? ☐Yes ☐No

B. Are you currently selling this plan in other states? ☐Yes ☐No

C. What market restrictions (such as available to military persons only), do you have on this form? _____

D. Is this filing a resubmission of a previously disapproved, withdrawn or incomplete filing? ☐Yes ☐No
If yes, provide Florida file log number: _____

E. Type of company: ☐Profit ☐Non-profit

SECTION IV. LIFE & HEALTH INSURANCE

A. Your policy or coverage is (check one)

- ☐ Health
- ☐ Life
- ☐ Variable Life
- ☐ Annuity
- ☐ Variable Annuity

B. Your policy or coverage is (Check one) ☐ Fraternal ☐ Individual ☐ Group

C. Group Policy Characteristics

1) ☐ In-state ☐ Out-of-state

2) ☐ Large Group Only ☐ Small Group Only (Major Medical - see section 627.6699, F.S.) ☐ Small Group Only (Other than Major Medical)
☐ Small and Large Groups (Other than Major Medical)

3) ☐ Employee Group ☐ Labor Union Group ☐ Debtor Group
☐ Association Group ☐ Additional Group ☐ Other (specify) _____

4) ☐ Blanket Health Policy ☐ Franchise Health Policy
☐ A group to cover persons associated in any other common group, which common group is formed primarily for purposes other than providing insurance.
☐ A group which is established primarily for the purpose of providing group insurance.
☐ A group of insurance agents of an insurer, which insurer is the policyholder.
☐ Other (specify) _____

D. Individual Policy Characteristics

☐ Optionally Renewable ☐ Guaranteed Renewable ☐ Non-Renewable
☐ Conditionally Renewable ☐ Non-Cancelable ☐ Other (specify) _____

E. Is your Policy or Coverage primarily for individuals over 65? ☐ Yes ☐ No

F. Check the types of benefit(s) your policy or coverage provides:

☐ Disability Income
☐ Long Term Care
☐ Medicare Supplement
☐ Health Maintenance Organization
☐ Major Medical
☐ Prepaid Limited Health Service Organization
☐ Small Employer Group Coverage (see Section 627.6699, F.S.)
☐ Other (specify)

SECTION V. RATE FILING HISTORY – INCLUDING ANNUAL RATE CERTIFICATIONS

(This section is for Florida experience only; not applicable for new form filings)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
		Total Annualized Premium Volume	# of Group Certificates or Individual Policies	Average Rate Change Requested (0.0% for ARC Filings)	Minimum Rate Change Requested (0.0% for ARC Filings)	Maximum Rate Change Requested (0.0% for ARC Filings)	Average Benefit Change Requested (0.0% for ARC Filings)			Effective Date of Change (N/A for ARC Filings)
Current Filing		$								
	Average Rate Change Requested	Total Annualized Premium Volume	# of Group Certificates or Individual Policies	Average Rate Change Approved	Minimum Rate Change Approved	Maximum Rate Change Approved	Average Benefit Change Approved	Date Change Approved or Acknowledged	Florida Filing Number	Effective Date of Change
1st Prior Filing	%	$		%	%	%	%			
2nd Prior Filing	%	$		%	%	%	%			

NOTE: Dates for columns (8) and (10) must be in the format mm/dd/yyyy.

SECTION VI. RATE REQUEST BY FORM – INCLUDING NEW FORM SUBMISSIONS

(To be completed for all rate filings, including ARC filings - Florida experience only.)

(1) Form Number	(2) Base Form or Rider	(3) Marketing Product Name (Street Name)	(4) Average Rate Change Requested (0.0% for ARC Filings)	(5) Minimum Rate Change Requested (0.0% for ARC Filings)	(6) Maximum Rate Change Requested (0.0% for ARC Filings)	(7) Average Benefit Change Requested (0.0% for ARC Filings)	(8) Total Annualized Premium Volume	(9) Total Incurred Claims	(10) # of Group Certificates or Individual Policies	(11) # of Covered Dependents/ Additional Lives	(12) # of Covered Lives (10+11)	(13) Inception Date or New Form	(14) Discontinued Date (If Applicable)	(15) Number of Member Months (Major Medical Only)	(16) Major Medical Coverage Type (Select All That Apply)
															HMO, PPO, Indemnity, POS, FFS, EPO, HSA, HDHP

MAJOR MEDICAL FORMS ONLY

Please enter one claim per row for each unique incurred claim over $500,000 for last five (5) years by year:

(1) Amount	(2) Incurral Year

SECTION VII. ADDITIONAL DATA FOR ALL RATE FILINGS

(Please provide current data for the form(s) included in the filing and listed in section VI.)

	Florida Only		Nationwide	
			☐ Same as Florida	
A. Number of Group Certificates or Individual Policies				
B. If Group, Average Number of Certificates Per Policy/ Participating Unit (e.g. Employer Unit)				
C. Total Annualized Premium Volume (Prior / Projected)	$	$	$	$
D. Total Incurred Claims (Prior / Projected)	$	$	$	$
E. Average Annual Premium (Current / Proposed or new form)	$	$	$	$
F. Anticipated Loss Ratio (Current / Proposed Premium)	%	%	%	%
G. Lifetime Loss Ratio (Current / Proposed Premium)	%	%	%	%

H. Target Loss Ratio for Individual or Group Forms (Not the Minimum; Expected Loss Ratio for Annually Rated Groups; Weighted average by form and/or group size where applicable)		%		%
I. Total Past Incurred Loss Ratio Without Active Life Reserve Increases		%		%
J. Latest Calendar Year Loss Ratio for Policies 3 Years & Older (For Med. Supp.) Without Policy Reserves:		%		%
K. Anticipated Actual-to-Expected Loss Ratio (Current / Proposed)	%	%	%	%
L. Lifetime Actual-to-Expected Loss Ratio (Current / Proposed)	%	%	%	%
M. Total Past Actual-to-Expected Loss Ratio		%		%
N. Valuation Date of Data (applies to all data in this section)				

SECTION VIII. Rate Filing Certification

I certify that I am authorized to make this Rate Filing on behalf of the company, further that the information contained in related transmittals and the filing is true, complete, correct, and in compliance with all applicable state laws.

(Check one)

☐ I am an actuary
☐ I am not an actuary

Name:	Title:

SECTION IX. Readability Certification

If you are not required to certify READABILITY compliance per Section 627.4145, F.S., please complete Section IX by checking the box, typing your name and substituting "READABILITY NOT APPLICABLE" in the title field.

I certify that the filing of this policy meets the requirements of Section 627.4145 (1), Florida Statutes, in the following manner (check one)

☐ the policy meets the minimum reading ease test score on the test used or;
☐ the score is lower than the minimum required but should be approved in accordance with Subsection 627.4145 (2), Florida Statues.

I acknowledge that the Office may require the submission of further information to verify this certification.

Name:	Title:

SECTION X. Checklist Certification

I have reviewed or supervised the review of the policy form(s) that this filing describes. I hereby certify that the statements made in this filing are in compliance with applicable Florida Statutes and Rules. I further certify it will be revised and/or discontinued if the Office determines that the form(s) does not comply with Florida law.

Name:	Title:

SECTION XI. Forms To Be Reviewed

Please provide the following information for the form(s) submitted with this filing.

Form Title	Form Number	Original Filing Number	Original Form Number

M E M O R A N D U M

DATE: November 15, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill DT
Jason Nelson JN

SUBJECT: Cabinet Agenda for December 11, 2012
Request for Approval to Publish Amendments to
Rule 69O-170.0155
Forms
Assignment # 127736-12

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before December 5, 2012 and to the Financial Services Commission on December 11, 2012, with a request to approve for publication the proposed rule.

The purpose of this rule amendment is to update and revise Form OIR-B1-1809 "Health Care Provider Certification of Eligibility" for Personal Injury Protection Benefits (PIP) due to statutory revisions as the result of H.B. 119 (Chapter 2012-197, Laws of Florida). The changes are technical edits to conform the form with the statute.

Sections 624.308(1), 627.711, 627.736, 215.5586, 624.307(1), 624.424, 627.0629, 627.0645, 627.711, 627.736, 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

M E M O R A N D U M

DATE: November 15, 2012

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for December 11, 2012
Request for Approval to Publish Amendments to
Rule 69O-176.013
Notification of Insured's Rights and Standard Disclosure Form; Personal Injury Protection Benefits
Assignment # 129415-12

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before December 5, 2012 and to the Financial Services Commission on December 11, 2012, with a request to approve for publication the proposed rules.

The purpose of this rule amendment is to update and revise Form OIR-B1-1149 " Notification of Personal Injury Protection Benefits" in accordance with revisions to the PIP law as amended by HB119 (Chapter 2012-197, Laws of Florida). The form was revised to reflect that PIP benefits are now allocated for emergency medical treatment and a flat $5,000 death benefit. The form was also revised to incorporate technical edits regarding fraud reporting and billing disclosures.

Sections 624.308(1), 627.7401(1), 624.307(1), 627.736, 627.7401, 627.745, 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-170.0155 Forms.

The following forms are hereby adopted and incorporated by reference:

(1) (a) through (m)- no change.

(n) OIR-B1-1809 "Health Care Provider Certification of Eligibility" (Rev 01/2013) ~~(New 1/2008)~~.

(2) No change.

Rulemaking Authority 624.308(1), 627.711, 627.736 FS. Law Implemented 215.5586, 624.307(1), 624.424, 627.062, 627.0629, 627.0645, 627.711, 627.736 FS. History–New 6-19-03, Formerly 4-170.0155, Amended 2-23-06, 12-26-06, 6-12-07, 7-17-07, 9-5-07, 3-13-08, 4-21-10 (1)(l), 4-21-10 (1)(k), 2-1-12 _____.

69O-176.013 Notification of Insured's Rights and Standard Disclosure Form; Personal Injury Protection Benefits.

(1) Each insurer issuing a policy in this state providing personal injury protection benefits shall mail or deliver Form OIR-B1-1149 (Revised 01/2013 ~~8/30/06~~) "Notification of Personal Injury Protection Benefits" to an insured within 21 days after receiving from the insured notice of an automobile accident or claim involving personal injury to an insured who is covered under the policy.

(2) Form OIR-B1-1571 (1/04) "Standard Disclosure and Acknowledgement Form – Personal Injury Protection – Initial Treatment or Service Provided" shall be utilized by providers as described in Section 627.736(5)(e), F.S.

(3) The forms in subsections (1) and (2) are incorporated herein by reference, and are available from Property and Casualty Product Review, 200 East Gaines St., Tallahassee, FL 32399-0330, or from the Office of Insurance Regulation website at www.floir.com and http://www/floir.com/pcfr/Documents/OIR-B1-1149.doc.

Rulemaking Authority 624.308(1), 627.7401(1) FS. Law Implemented 624.307(1), 627.736, 627.7401, 627.745 FS. History–New 10-1-94, Amended 12-6-00, 1-20-02, Formerly 4-176.013, Amended 3-8-04, 8-23-07.

OFFICE OF INSURANCE REGULATION
PROPERTY & CASUALTY PRODUCT REVIEW

HEALTH CARE PROVIDER CERTIFICATION OF ELIGIBILITY FOR PIP BENEFITS

(This form is to be provided to the insurer providing coverage for injured patient)

I, _____, _____ pursuant to Section
(Print or type name) (Print or type title)
627.736(1)(a), Florida Statutes, under oath do swear and attest, based on the signing health care provider's personal knowledge, under penalty of perjury, that medical benefits as described in Section 627.736(1)(a), Florida Statutes are being provided by:

(Check all applicable boxes)

☐ 1. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such ~~practitioner or~~ practitioners and the spouse, parent, child, or sibling of such ~~that practitioner or those~~ practitioners.

Please list the name(s), address(es), Florida practice license number(s) (including prefixes and suffixes, if any), and the percentage owned by each licensed health care practitioner having an ownership interest in the clinic. (Please add additional pages if necessary)

Name	Address	License Number	% Owned
Enter total from family members, below			
	Add all percentages owned. This sum must equal 100%		**100%**

Identification of Family Member Owners (When Applicable): Please provide requested information for the spouse, child, sibling or parent of the health care practitioner who has an ownership interest in the clinic, and the percentage owned. (Please add additional pages if necessary.)

Name	Address	Relationship to Practitioner	% Owned
	Enter % here and on Family Member Total, above (Add all percentages owned)		

☐ 2. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

Name of Hospital: _____

Explanation of ownership relationship to Hospital:

_____

_____

_____

☐ 3. A health care clinic licensed under Part X of Chapter 400, ~~Sections 400.990-400.995~~ Florida Statutes which ~~that~~ is:

☐ a. Accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; or

Please state the name of the accrediting agency and the date of current accreditation:

_____Date_____

☐ b. A health care clinic that:

☐ 1. Has a medical director licensed under chapter 458, chapter 459, or chapter 460; and give the full name of Medical Director shown on the Board license and telephone number where director may be contacted.

Name on License_____ Lic.No._____

Telephone #_____

☐ 2. Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

- HCC License #_____, effective date first HCC license_____
- Name of Exchange (i.e. NYSE, NASDAQ) and Exchange symbol for company:

_____

☐ 3. Provides at least four of the following medical specialties:

☐ General medicine	☐ Orthopedic medicine	☐ Radiography
☐ Physical therapy	☐ Physical medicine	☐ Physical rehabilitation
☐ Prescribing or dispensing outpatient prescription medication	☐ Laboratory services	

Note: Items 3. b. 1, 2 & 3 above are all required for eligibility.

_____ _____
(Signature) Executive Officer, Medical or Clinic Director (Title)

_____ _____
(Print or Type Name) (Board or Department of Health License No. with suffix)

_____
(Corporate Name of Entity or Clinic, as filed with Florida Department of State, i.e. Inc., LLC, LLP, P.A., etc.)

_____
(Address) (City) (State) (Zip) (Phone)

(AFTER AN INITIAL, NOTARIZED SUBMISSION TO AN INSURER THIS FORM MAY BE COPIED FOR SUBMISSION TO THAT INSURER, PROVIDED THERE HAS BEEN NO CHANGE TO THE INFORMATION CONTAINED ON THE FORM.)

Notarization of Health Care Provider:

STATE OF _____
COUNTY OF_____

Sworn to and subscribed before me this _____day of _____, 20__, by _____.

Personally Known_____OR Produced Identification_____(Type of Identification Produced)

Notary Signature _____

My commission expires: _____

NOTIFICATION OF PERSONAL INJURY PROTECTION BENEFITS
YOUR PERSONAL INJURY PROTECTION RIGHTS AND BENEFITS UNDER THE FLORIDA MOTOR VEHICLE NO-FAULT LAW

The Florida Motor Vehicle No-Fault Law does two things:

(1) It establishes a limited exemption from liability for injuries caused to others in an automobile accident; and

(2) It establishes personal injury protection (PIP) benefits to pay for certain losses resulting from an accident.

LEGAL RESPONSIBILITIES AND RIGHTS

Who is covered?

(1) If you are a resident of Florida and own a motor vehicle, you are required to purchase PIP. You are covered by PIP if you are the named insured. You, the insured, are covered by PIP while driving your vehicle or when a passenger in another's vehicle. You are also covered while outside a motor vehicle if struck and injured by a motor vehicle.

(2) Resident relatives who live with you, the insured, may be covered by your PIP benefits while they are driving your car, as passengers in your or another's car, and while pedestrians if struck and injured by a motor vehicle.

(3) Others who are injured while driving your insured motor vehicle or who are injured while a passenger in your insured motor vehicle or who are injured as a pedestrian when struck by your insured motor vehicle may be covered by your PIP.

(4) If you or your insured relatives living with you are injured while outside Florida, and are in your insured motor vehicle, you and your insured relatives are covered under PIP as long as the injury occurs within the United States, its territories or possessions, or in Canada

FRAUD ADVISORY NOTICE: Solicitation of a person injured in a motor vehicle crash for purposes of filing personal injury protection or tort claims could be a violation of Florida law or the rules regulating The Florida Bar and should be immediately reported to the Division of Insurance Fraud on-line at www.MyFloridaCFO~~fldfs~~.com/fraud or by calling 1-800-378-0445 from within Florida or 850-413-3261 from outside of Florida.

EXCEPTIONS

If your passengers or relatives living with you have a motor vehicle licensed in Florida or own a motor vehicle required to be licensed in Florida, they are not covered by your PIP coverage. They must purchase PIP for themselves to have coverage.

EXCLUSIONS

An insurer may exclude no-fault benefits:

(1) For injury sustained by any person operating the insured motor vehicle without your express or implied consent.

(2) To any injured person, if his/her conduct contributed to the injury under either of the following circumstances:

(a) causing injury to himself intentionally; or

(b) being injured while committing a felony.

(3) For injuries sustained by the named insured and relatives residing in the same household while occupying another motor vehicle owned by the named insured and not insured under the policy.

BENEFITS

The minimum limits for no-fault personal injury protection benefits are: ~~is~~

- $10,000 per person for loss ~~sustained as a~~ resulting from ~~of~~ bodily injury, sickness, or disease arising out of the ownership, maintenance, or use of a motor vehicle if a physician, dentist, physician assistant, or advanced registered nurse practitioner has determined that the injured person had an emergency medical condition. ~~($5,000 death) arising out of the ownership, maintenance, or use of a motor vehicle.~~
- $2,500 per person for loss resulting from bodily injury, sickness, or disease arising out of the ownership, maintenance, or use of a motor vehicle if a physician, dentist, chiropractic physician, physician assistant, advanced registered nurse practitioner, physical therapist or person licensed to provide emergency transportation and treatment has determined that the injured person did not have an emergency medical condition,
- Disability benefits, which combined with medical benefits cannot exceed $10,000, and
- $5,000 per individual for death benefits.

MEDICAL PAYMENTS

PIP medical benefits pays 80 percent of ~~medical benefits~~ for all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, ~~wheelchairs, crutches, slings, neck braces and splints.~~ and mMedically necessary ambulance, hospital and nursing services ~~are covered, and benefits also are paid for necessary remedial treatment and services recognized and permitted under the laws of the state for an injured person who relies solely upon spiritual means through prayer for healing because of religious beliefs.~~ . Medical benefits are only paid if the individual receives initial services and care within 14 days after the motor vehicle accident. Medical benefits do not include massage or acupuncture, regardless of the person, entity, or licensee providing massage or acupuncture and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits.

Note: Iif you have medical payments coverage through your auto insurance policy, then the medical payments coverage will be secondary to PIP coverage. The excess medical expenses, the 20 percent not covered by PIP, and the deductible may or may not be covered by the additional medical payments coverage depending on your particular policy.

BILLING REQUIREMENTS

Florida law ~~Statutes~~ provides that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The insured has a responsibility to furnish the provider with the correct name and address of the personal injury protection insurer. Failure to do so may result in delayed reimbursements to the provider.

At your initial treatment or service provided you will be required to sign a disclosure and acknowledgement form stating that the services were actually rendered, it is your right and duty to confirm that those services were rendered, you were not solicited to seek services from the

provider, the provider explained the services, and if you notify the insurer of a billing error you may be entitled to a share of the insurer's savings.

ADVISORY NOTICE: You may be entitled to a certain percentage of a reduction in the amount paid by the motor vehicle insurer if you notify that insurer of a billing error.

DISABILITY BENEFITS

PIP pays 60 percent of disability benefits for any loss of gross income and loss of earning capacity per individual from inability to work because of an injury sustained in an accident. Disability benefits also cover all expenses reasonably incurred for household services that, if not for injury, the injured person would have performed. Benefits must be paid not less than every two weeks.

DEATH BENEFITS

PIP pays ~~up to~~ $5,000 ~~of available benefits~~ per individual in death benefits. Death benefits are in addition to the medical and disability benefits provided under the insurance policy. The insurer may pay death ~~such~~ benefits to the executor or administrator of the deceased, to any of the deceased's relatives, including those related by marriage, or to any person appearing to the insurer to be equitably entitled to the payment.

OPTIONAL DEDUCTIBLES AND LIMITATIONS

1. Persons subject to deductibles may be able to recover the amount of the deductible from a tortfeasor otherwise exempt from liability under Section 627.737, F.S.
2. Deductibles must be applied to the entire amount of any expenses and losses described under required personal injury protection benefits. After the deductible is met, each insured is eligible to receive up to $10,000 in benefits. Thus, for instance, an insured with a $1,000 deductible would have to incur $13,500 in medical expenses (assuming no disability or death benefits) in order to receive the entire $10,000 in benefits [($13,500-$1,000) x 80%].
3. Deductibles of $250, $500 and $1,000 must be offered but may not be required.
4. You may have elected that the benefits from loss of gross income and loss of earning capacity (disability benefits) be excluded from your PIP benefits.

COORDINATION OF BENEFITS

PIP benefits are primary over other insurance coverage, except that workers' compensation benefits received will be credited against PIP benefits. This means that your PIP insurer is ultimately responsible for payment of your claim. How this works in a specific situation depends upon the contract language in the other insurance policy.

PAYMENT OF BENEFITS

PIP benefits will be payable as loss accrues and reasonable proof of the loss and the expenses are provided. Before PIP benefits are paid, an insurer may require written notice be given as soon as possible after an accident involving a motor vehicle.

PIP benefits are overdue if not paid within 30 days after the insurer is provided written notice of a covered loss and of the total amount of the claim. If a partial claim is made, that partial amount must be paid within 30 days after the insurer receives written notice.

Any part, or all of the remainder, of the claim that is later supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. However, any payment shall not be deemed overdue when the insurer has reasonable proof showing that the insurer is not responsible for the payment even though written notice has been furnished to the insurer.

For the purpose of calculating overdue payments, payment is considered as being made on the date it was postmarked or, if not posted, on the date of delivery. All overdue payments will pay simple interest at the rate established in your policy, or pursuant to s. 55.03, F.S., whichever is greater.

WHAT DO I DO TO RESOLVE DISPUTES REGARDING PIP BENEFITS?

(1) In the event you are having a dispute with the insurer for PIP benefits, you may demand mediation of the claim before resorting to the courts by filing a request with the Department of Financial Services "Department" on Form DFS-10~~H2~~-510 provided by the Department.

(2) Mediation is an informal process whereby a neutral mediator selected by the Department ~~Office~~ will work together with you and the insurer to resolve the dispute.

You may reach the Department at 877-693-5236 within Florida or 850-413-3089 from out of state ~~a local service office or call 1-800-342-2762.~~

PLEASE NOTE: This description of your rights contains general statements and should not be construed to enhance, alter, or amend your rights under your policy and Florida law.

FRAUD ADVISORY NOTICE: The Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of certain Florida Statutes. You may report such fraud on-line at www.MyFloridaCFO~~fldfs~~.com/fraud or by calling 1-800-378-0445 from within Florida or 850-413-3261 from outside of Florida.

69O-176.013
Rulemaking Authority

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

627.7401 Notification of insured's rights.—
(1) The commission, by rule, shall adopt a form for the notification of insureds of their right to receive personal injury protection benefits under the Florida Motor Vehicle No-Fault Law. Such notice shall include:
(a) A description of the benefits provided by personal injury protection, including, but not limited to, the specific types of services for which medical benefits are paid, disability benefits, death benefits, significant exclusions from and limitations on personal injury protection benefits, when payments are due, how benefits are coordinated with other insurance benefits that the insured may have, penalties and interest that may be imposed on insurers for failure to make timely payments of benefits, and rights of parties regarding disputes as to benefits.
(b) An advisory informing insureds that:
1. Pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.
2. Pursuant to s. 627.736(5)(e)1., if the insured notifies the insurer of a billing error, the insured may be entitled to a certain percentage of a reduction in the amount paid by the insured's motor vehicle insurer.
(c) A notice that solicitation of a person injured in a motor vehicle crash for purposes of filing personal injury protection or tort claims could be a violation of s. 817.234, s 817.505, or the rules regulating The Florida Bar and should be immediately reported to the Division of Insurance Fraud if such conduct has taken place.
(2) Each insurer issuing a policy in this state providing personal injury protection benefits must mail or deliver the notice as specified in subsection (1) to an insured within 21 days after receiving from the insured notice of an automobile accident or claim involving personal injury to an insured who is covered under the policy. The office may allow an insurer additional time to provide the notice specified in subsection (1) not to exceed 30 days, upon a showing by the insurer that an emergency justifies an extension of time.
(3) The notice required by this section does not alter or modify the terms of the insurance contract or other requirements of this act.

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

627.736 Required personal injury protection benefits; exclusions; priority; claims.—
(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:
(a) Medical benefits.—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing services if the individual receives

initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner licensed under chapter 464. Followup services and care may also be provided by any of the following persons or entities:

a. A hospital or ambulatory surgical center licensed under chapter 395.

b. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

c. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in this subparagraph.

e. A health care clinic licensed under part X of chapter 400 which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc., or

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to $10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to $2,500 if any provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage or

acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.

(b) Disability benefits.—Sixty percent of any loss of gross income and loss of earning capacity per individual from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision must be paid at least every 2 weeks.

(c) Death benefits.—Death benefits of $5,000 per individual. Death benefits are in addition to the medical and disability benefits provided under the insurance policy. The insurer may pay death benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood, legal adoption, or marriage, or to any person appearing to the insurer to be equitably entitled to such benefits.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

(2) AUTHORIZED EXCLUSIONS.—Any insurer may exclude benefits:

(a) For injury sustained by the named insured and relatives residing in the same household while occupying another motor vehicle owned by the named insured and not insured under the policy or for injury sustained by any person operating the insured motor vehicle without the express or implied consent of the insured.

(b) To any injured person, if such person's conduct contributed to his or her injury under any of the following circumstances:

1. Causing injury to himself or herself intentionally; or
2. Being injured while committing a felony.

Whenever an insured is charged with conduct as set forth in subparagraph 2., the 30-day payment provision of paragraph (4)(b) shall be held in abeyance, and the insurer shall withhold payment of any personal injury protection benefits pending the outcome of the case at the trial level. If the charge is nolle prossed or dismissed or the insured is acquitted, the 30-day payment provision shall run from the date the insurer is notified of such action.

(3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN TORT CLAIMS.—No insurer shall have a lien on any recovery in tort by judgment, settlement, or otherwise for personal injury protection benefits, whether suit has been filed or settlement has been reached without suit. An injured party who is entitled to bring suit under the provisions of ss. 627.730-627.7405, or his or her legal representative, shall have no right to recover any damages for which personal injury protection benefits are paid or payable. The plaintiff may prove all of his or her special damages notwithstanding this limitation, but if special

damages are introduced in evidence, the trier of facts, whether judge or jury, shall not award damages for personal injury protection benefits paid or payable. In all cases in which a jury is required to fix damages, the court shall instruct the jury that the plaintiff shall not recover such special damages for personal injury protection benefits paid or payable.

(4) PAYMENT OF BENEFITS.—Benefits due from an insurer under ss. 627.730-627.7405 are primary, except that benefits received under any workers' compensation law must be credited against the benefits provided by subsection (1) and are due and payable as loss accrues upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. If the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, the benefits under ss. 627.730-627.7405 are subject to the Medicaid program. However, within 30 days after receiving notice that the Medicaid program paid such benefits, the insurer shall repay the full amount of the benefits to the Medicaid program.

(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by ss. 627.730-627.7405.

(b) Personal injury protection insurance benefits paid pursuant to this section are overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. However:

1. If written notice of the entire claim is not furnished to the insurer, any partial amount supported by written notice is overdue if not paid within 30 days after written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after written notice is furnished to the insurer.

2. If an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge if this does not limit the introduction of evidence at trial. The insurer must also include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence.

3. If an insurer pays only a portion of a claim or rejects a claim due to an alleged error in the claim, the insurer, at the time of the partial payment or rejection, shall provide an itemized specification or explanation of benefits due to the specified error. Upon receiving the specification or explanation, the person making the claim, at the person's option and without waiving any other legal remedy for payment, has 15 days to submit a revised claim, which shall be considered a timely submission of written notice of a claim.

4. Notwithstanding the fact that written notice has been furnished to the insurer, payment is not overdue if the insurer has reasonable proof that the insurer is not responsible for the payment.

5. For the purpose of calculating the extent to which benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.

6. This paragraph does not preclude or limit the ability of the insurer to assert that the claim was unrelated, was not medically necessary, or was unreasonable or that the amount of the charge was in excess of that permitted under, or in violation of, subsection (5). Such assertion may be made at any time, including after payment of the claim or after the 30-day period for payment set forth in this paragraph.

(c) Upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002, or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of such claims may be used by the insurer to pay other claims. The time periods specified in paragraph (b) for payment of personal injury protection benefits are tolled for the period of time that an insurer is required to hold payment of a claim that is not from such physician or dentist to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

(d) All overdue payments bear simple interest at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, for the quarter in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of covered loss. Interest is due at the time payment of the overdue claim is made.

(e) The insurer of the owner of a motor vehicle shall pay personal injury protection benefits for:

1. Accidental bodily injury sustained in this state by the owner while occupying a motor vehicle, or while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with a motor vehicle.

2. Accidental bodily injury sustained outside this state, but within the United States of America or its territories or possessions or Canada, by the owner while occupying the owner's motor vehicle.

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2., if the relative at the time of the accident is domiciled in the owner's household and is not the owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405.

4. Accidental bodily injury sustained in this state by any other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with such motor vehicle, if the injured person is not:

a. The owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405; or

b. Entitled to personal injury benefits from the insurer of the owner of such a motor vehicle.

(f) If two or more insurers are liable for paying personal injury protection benefits for the same injury to any one person, the maximum payable is as specified in subsection (1), and the insurer paying the benefits is entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.

(g) It is a violation of the insurance code for an insurer to fail to timely provide benefits as required by this section with such frequency as to constitute a general business practice.

(h) Benefits are not due or payable to or on the behalf of an insured person if that person has committed, by a material act or omission, insurance fraud relating to personal injury protection coverage under his or her policy, if the fraud is admitted to in a sworn statement by the insured or established in a court of competent jurisdiction. Any insurance fraud voids all coverage arising from the claim related to such fraud under the personal injury protection coverage of the insured person who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid before the

discovery of the fraud is recoverable by the insurer in its entirety from the person who committed insurance fraud. The prevailing party is entitled to its costs and attorney fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph.

(i) If an insurer has a reasonable belief that a fraudulent insurance act, for the purposes of s. 626.989 or s. 817.234, has been committed, the insurer shall notify the claimant, in writing, within 30 days after submission of the claim that the claim is being investigated for suspected fraud. Beginning at the end of the initial 30-day period, the insurer has an additional 60 days to conduct its fraud investigation. Notwithstanding subsection (10), no later than 90 days after the submission of the claim, the insurer must deny the claim or pay the claim with simple interest as provided in paragraph (d). Interest shall be assessed from the day the claim was submitted until the day the claim is paid. All claims denied for suspected fraudulent insurance acts shall be reported to the Division of Insurance Fraud.

(j) An insurer shall create and maintain for each insured a log of personal injury protection benefits paid by the insurer on behalf of the insured. If litigation is commenced, the insurer shall provide to the insured a copy of the log within 30 days after receiving a request for the log from the insured.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a) A physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. However, such a charge may not exceed the amount the person or institution customarily charges for like services or supplies. In determining whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

1. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002 provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under:

(I) The participating physicians fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

However, if such services, supplies, or care is not reimbursable under Medicare Part B, as provided in this sub-subparagraph, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

2. For purposes of subparagraph 1., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the year in which the services, supplies, or care is rendered and for the area in which such services, supplies, or care is rendered, and the applicable fee schedule or payment limitation applies throughout the remainder of that year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

3. Subparagraph 1. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes. However, subparagraph 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

4. If an insurer limits payment as authorized by subparagraph 1., the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.

5. Effective July 1, 2012, an insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

(b)1. An insurer or insured is not required to pay a claim or charges:

a. Made by a broker or by a person making a claim on behalf of a broker;

b. For any service or treatment that was not lawful at the time rendered;

c. To any person who knowingly submits a false or misleading statement relating to the claim or charges;

d. With respect to a bill or statement that does not substantially meet the applicable requirements of paragraph (d);

e. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines have been

improperly or incorrectly upcoded or unbundled and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, if, before doing so, the insurer contacts the health care provider and discusses the reasons for the insurer's change and the health care provider's reason for the coding, or makes a reasonable good faith effort to do so, as documented in the insurer's file; and

f. For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.

2. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits under this section. The list shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and may not be dependent for results entirely upon subjective patient response. Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for an invalid diagnostic test as determined by the Department of Health.

(c) With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services and care as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider may not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

1. If the insured fails to furnish the provider with the correct name and address of the insured's personal injury protection insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of the charges. The insurer is not required to pay for such charges unless the provider includes with the statement documentary evidence that was provided by the insured during the 35-day period demonstrating that the provider reasonably relied on erroneous information from the insured and either:

a. A denial letter from the incorrect insurer; or

b. Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.

2. For emergency services and care rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph, and the insurer is not considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph (d), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the federal Centers for Medicare and Medicaid Services.

3. Each notice of the insured's rights under s. 627.7401 must include the following statement in at least 12-point type:

BILLING REQUIREMENTS.—Florida law provides that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

(d) All statements and bills for medical services rendered by a physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers must, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the CMS 1500 form instructions, the American Medical Association CPT Editorial Panel, and the HCPCS. All providers, other than hospitals, must include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General, Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. A statement of medical services may not include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer is not considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph and are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

(e)1. At the initial treatment or service provided, each physician, other licensed professional, clinic, or other medical institution providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:

a. The insured, or his or her guardian, must countersign the form attesting to the fact that the services set forth therein were actually rendered;

b. The insured, or his or her guardian, has both the right and affirmative duty to confirm that the services were actually rendered;

c. The insured, or his or her guardian, was not solicited by any person to seek any services from the medical provider;

d. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed explained the services to the insured or his or her guardian; and

e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services

rendered to the insured, or his or her guardian, so that the insured, or his or her guardian, countersigns the form with informed consent.

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or other services that are of such a nature that they are not required to be performed in the presence of the insured.

4. The licensed medical professional rendering treatment for which payment is being claimed must sign, by his or her own hand, the form complying with this paragraph.

5. The original completed disclosure and acknowledgment form shall be furnished to the insurer pursuant to paragraph (4)(b) and may not be electronically furnished.

6. The disclosure and acknowledgment form is not required for services billed by a provider for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.

7. The Financial Services Commission shall adopt, by rule, a standard disclosure and acknowledgment form to be used to fulfill the requirements of this paragraph.

8. As used in this paragraph, the term "countersign" or "countersignature" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement.

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, which is consistent with the services being rendered to the patient as claimed. The requirement to maintain a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

(f) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine if the insured was properly billed for only those services and treatments that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured, the person making the written notification, and the provider of its findings and reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to a written notification by any person, the insurer shall pay to the person 20 percent of the amount of the reduction, up to $500. If the provider is arrested due to the improper billing, the insurer shall pay to the person 40 percent of the amount of the reduction, up to $500.

(g) An insurer may not systematically downcode with the intent to deny reimbursement otherwise due. Such action constitutes a material misrepresentation under s. 626.9541(1)(i)2.

(h) As provided in s. 400.9905, an entity excluded from the definition of a clinic shall be deemed a clinic and must be licensed under part X of chapter 400 in order to receive reimbursement under ss. 627.730-627.7405. However, this licensing requirement does not apply to:

1. An entity wholly owned by a physician licensed under chapter 458 or chapter 459, or by the physician and the spouse, parent, child, or sibling of the physician;

2. An entity wholly owned by a dentist licensed under chapter 466, or by the dentist and the spouse, parent, child, or sibling of the dentist;

3. An entity wholly owned by a chiropractic physician licensed under chapter 460, or by the chiropractic physician and the spouse, parent, child, or sibling of the chiropractic physician;

4. A hospital or ambulatory surgical center licensed under chapter 395;

5. An entity that wholly owns or is wholly owned, directly or indirectly, by a hospital or hospitals licensed under chapter 395; or

6. An entity that is a clinical facility affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

(6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.—

(a) If a request is made by an insurer providing personal injury protection benefits under ss. 627.730-627.7405 against whom a claim has been made, an employer must furnish, in a form approved by the office, a sworn statement of the earnings, since the time of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested by the insurer against whom the claim has been made, furnish a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce, and allow the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment if this does not limit the introduction of evidence at trial. Such sworn statement must read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." A cause of action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought against any physician, hospital, clinic, or other medical institution complying with this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount that is the subject of the insurer's inquiry is overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. As used in this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. An insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

(c) In the event of a dispute regarding an insurer's right to discovery of facts under this section, the insurer may petition a court of competent jurisdiction to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and must specify the time, place, manner, conditions, and scope of the discovery. In order to protect against annoyance, embarrassment, or oppression, as justice requires, the court may enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.

(d) The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under this section, and pay a reasonable charge, if required by the insurer.

(e) Notice to an insurer of the existence of a claim may not be unreasonably withheld by an insured.

(f) In a dispute between the insured and the insurer, or between an assignee of the insured's rights and the insurer, upon request, the insurer must notify the insured or the assignee that the policy limits under this section have been reached within 15 days after the limits have been reached.

(6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.—

(a) If a request is made by an insurer providing personal injury protection benefits under ss. 627.730-627.7405 against whom a claim has been made, an employer must furnish, in a form approved by the office, a sworn statement of the earnings, since the time of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested by the insurer against whom the claim has been made, furnish a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce, and allow the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment if this does not limit the introduction of evidence at trial. Such sworn statement must read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." A cause of action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought against any physician, hospital, clinic, or other medical institution complying with this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount that is the subject of the insurer's inquiry is overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. As used in this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. An insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

(c) In the event of a dispute regarding an insurer's right to discovery of facts under this section, the insurer may petition a court of competent jurisdiction to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and must specify the time, place, manner, conditions, and scope of the discovery. In order to protect against annoyance, embarrassment, or oppression, as justice requires, the court may enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.

(d) The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under this section, and pay a reasonable charge, if required by the insurer.

(e) Notice to an insurer of the existence of a claim may not be unreasonably withheld by an insured.

(f) In a dispute between the insured and the insurer, or between an assignee of the insured's rights and the insurer, upon request, the insurer must notify the insured or the assignee that the policy limits under this section have been reached within 15 days after the limits have been reached.

(g) An insured seeking benefits under ss. 627.730–627.7405, including an omnibus insured, must comply with the terms of the policy, which include, but are not limited to, submitting to an examination under oath. The scope of questioning during the examination under oath is limited to relevant information or information that could reasonably be expected to lead to relevant information. Compliance with this paragraph is a condition precedent to receiving benefits. An insurer that, as a general business practice as determined by the office, requests an examination under oath of an insured or an omnibus insured without a reasonable basis is subject to s. 626.9541.

(7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.—

(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides, or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a valid report by a Florida physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary. A valid report is one that is prepared and signed by the physician examining the injured person or reviewing the treatment records of the injured person and is factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that during the 3 years immediately preceding the date of the physical examination or review of the treatment records the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions or to the instruction of students in an accredited health professional school or accredited residency program or a clinical research program that is affiliated with an accredited health professional school or teaching hospital or accredited residency program. The physician preparing a report at the request of an insurer and physicians rendering expert opinions on behalf of persons claiming medical benefits for personal injury protection, or on behalf of an insured through an attorney or another entity, shall maintain, for at least 3 years, copies of all examination reports as medical records and shall maintain, for at least 3 years, records of all payments for the examinations and reports. Neither an insurer nor any person acting at the direction of or on behalf of an insurer may materially change an opinion in a report prepared under this paragraph or direct the physician preparing the report to change such opinion. The denial of a payment as the result of such a changed opinion constitutes a material misrepresentation under s. 626.9541(1)(i)2.; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file.

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by

an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit to or fails to appear at an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits. An insured's refusal to submit to or failure to appear at two examinations raises a rebuttable presumption that the insured's refusal or failure was unreasonable.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY FEES.—With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, the provisions of ss. 627.428 and 768.79 apply, except as provided in subsections (10) and (15), and except that any attorney fees recovered must:

(a) Comply with prevailing professional standards;

(b) Not overstate or inflate the number of hours reasonably necessary for a case of comparable skill or complexity; and

(c) Represent legal services that are reasonable and necessary to achieve the result obtained.

Upon request by either party, a judge must make written findings, substantiated by evidence presented at trial or any hearings associated therewith, that any award of attorney fees complies with this subsection. Notwithstanding s. 627.428, attorney fees recovered under ss. 627.730-627.7405 must be calculated without regard to a contingency risk multiplier.

(9) PREFERRED PROVIDERS.—An insurer may negotiate and contract with preferred providers for the benefits described in this section, which include health care providers licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchasing the policy for personal injury protection benefits, if the requirements of this subsection are met. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer shall provide each insured with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the insurer's principal office within the state.

(10) DEMAND LETTER.—

(a) As a condition precedent to filing any action for benefits under this section, written notice of an intent to initiate litigation must be provided to the insurer. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b).

(b) The notice must state that it is a "demand letter under s. 627.736" and state with specificity:

1. The name of the insured upon which such benefits are being sought, including a copy of the assignment giving rights to the claimant if the claimant is not the insured.
2. The claim number or policy number upon which such claim was originally submitted to the insurer.
3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (5)(d) or the lost-wage statement previously submitted may be used as the itemized statement. To the extent that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.

(c) Each notice required by this subsection must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs shall be reimbursed by the insurer if requested by the claimant in the notice, when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office the name and address of the designated person to whom notices must be sent which the office shall make available on its Internet website. The name and address on file with the office pursuant to s. 624.422 is deemed the authorized representative to accept notice pursuant to this subsection if no other designation has been made.

(d) If, within 30 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, no action may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, no action may be brought against the insurer if, within 30 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section. To the extent the insurer determines not to pay any amount demanded, the penalty is not payable in any subsequent action. For purposes of this subsection, payment or the insurer's agreement shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer is not obligated to pay any attorney fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

(e) The applicable statute of limitation for an action under this section shall be tolled for 30 business days by the mailing of the notice required by this subsection.

(11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE PRACTICE.—

(a) An insurer is engaging in a prohibited unfair or deceptive practice that is subject to the penalties provided in s. 626.9521 and the office has the powers and duties specified in ss. 626.9561-626.9601 if the insurer, with such frequency so as to indicate a general business practice:

1. Fails to pay valid claims for personal injury protection; or
2. Fails to pay valid claims until receipt of the notice required by subsection (10).

(b) Notwithstanding s. 501.212, the Department of Legal Affairs may investigate and initiate actions for a violation of this subsection, including, but not limited to, the powers and duties specified in part II of chapter 501.

(12) CIVIL ACTION FOR INSURANCE FRAUD.—An insurer shall have a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section. An insurer prevailing in an action brought under this subsection may recover compensatory, consequential, and punitive damages subject to the requirements and limitations of part II of chapter 768, and attorney's fees and costs incurred in litigating a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section.

(13) MINIMUM BENEFIT COVERAGE.—If the Financial Services Commission determines that the cost savings under personal injury protection insurance benefits paid by insurers have been realized due to the provisions of this act, prior legislative reforms, or other factors, the commission may increase the minimum $10,000 benefit coverage requirement. In establishing the amount of such increase, the commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized for the personal injury protection coverage with limits of $10,000.

(14) FRAUD ADVISORY NOTICE.—Upon receiving notice of a claim under this section, an insurer shall provide a notice to the insured or to a person for whom a claim for reimbursement for diagnosis or treatment of injuries has been filed, advising that:

(a) Pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

(b) Solicitation of a person injured in a motor vehicle crash for purposes of filing personal injury protection or tort claims could be a violation of s. 817.234, s. 817.505, or the rules regulating The Florida Bar and should be immediately reported to the Division of Insurance Fraud if such conduct has taken place.

(15) ALL CLAIMS BROUGHT IN A SINGLE ACTION.—In any civil action to recover personal injury protection benefits brought by a claimant pursuant to this section against an insurer, all claims related to the same health care provider for the same injured person shall be brought in one action, unless good cause is shown why such claims should be brought separately. If the court determines that a civil action is filed for a claim that should have been brought in a prior civil action, the court may not award attorney's fees to the claimant.

(16) SECURE ELECTRONIC DATA TRANSFER.—A notice, documentation, transmission, or communication of any kind required or authorized under ss. 627.730-627.7405 may be transmitted electronically if it is transmitted by secure electronic data transfer that is consistent with state and federal privacy and security laws.

(17) NONREIMBURSIBLE CLAIMS.—Claims generated as a result of activities that are unlawful pursuant to s. 817.505 are not reimbursable under the Florida Motor Vehicle No-Fault Law.

627.745 Mediation of claims.—

(1)(a) In any claim filed with an insurer for personal injury in an amount of $10,000 or less or any claim for property damage in any amount, arising out of the ownership, operation, use, or maintenance of a motor vehicle, either party may demand mediation of the claim prior to the institution of litigation.

(b) A request for mediation shall be filed with the department on a form approved by the department. The request for mediation shall state the reason for the request for mediation and the issues in dispute which are to be mediated. The filing of a request for mediation tolls the applicable time requirements for filing suit for a period of 60 days following the conclusion of the mediation process or the time prescribed in s. 95.11, whichever is later.

(c) The insurance policy must specify in detail the terms and conditions for mediation of a first-party claim.

(d) The mediation shall be conducted as an informal process in which formal rules of evidence and procedure need not be observed. Any party participating in a mediation must have the authority to make a binding decision. All parties must mediate in good faith.

(e) The department shall randomly select mediators. Each party may once reject the mediator selected, either originally or after the opposing side has exercised its option to reject a mediator.

(f) Costs of mediation shall be borne equally by both parties unless the mediator determines that one party has not mediated in good faith.

(g) Only one mediation may be requested for each claim, unless all parties agree to further mediation.

(2) Upon receipt of a request for mediation, the department shall refer the request to a mediator. The mediator shall notify the applicant and all interested parties, as identified by the applicant, and any other parties the mediator believes may have an interest in the mediation, of the date, time, and place of the mediation conference. The conference may be held by telephone, if feasible. The mediation conference shall be held within 45 days after the request for mediation.

(3)(a) The department shall approve mediators to conduct mediations pursuant to this section. All mediators must file an application under oath for approval as a mediator.

(b) To qualify for approval as a mediator, a person must meet the following qualifications:

1. Possess a masters or doctorate degree in psychology, counseling, business, accounting, or economics, be a member of The Florida Bar, be licensed as a certified public accountant, or demonstrate that the applicant for approval has been actively engaged as a qualified mediator for at least 4 years prior to July 1, 1990.

2. Within 4 years immediately preceding the date the application for approval is filed with the department, have completed a minimum of a 40-hour training program approved by the department and successfully passed a final examination included in the training program and approved by the department. The training program shall include and address all of the following:

a. Mediation theory.

b. Mediation process and techniques.

c. Standards of conduct for mediators.

d. Conflict management and intervention skills.

e. Insurance nomenclature.

(4) The department must adopt rules of procedure for claims mediation, taking into consideration a system which:

(a) Is fair.

(b) Promotes settlement.

(c) Avoids delay.

(d) Is nonadversarial.

(e) Uses a framework for modern mediating technique.

(f) Controls costs and expenses of mediation.

(5) Disclosures and information divulged in the mediation process are not admissible in any subsequent action or proceeding relating to the claim or to the cause of action giving rise to the claim. A person demanding mediation under this section may not demand or request mediation after a suit is filed relating to the same facts already mediated.

624.308 Rules.—

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

627.711 Notice of premium discounts for hurricane loss mitigation; uniform mitigation verification inspection form.—

(1) Using a form prescribed by the Office of Insurance Regulation, the insurer shall clearly notify the applicant or policyholder of any personal lines residential property insurance policy, at the time of the issuance of the policy and at each renewal, of the availability and the range of each premium discount, credit, other rate differential, or reduction in deductibles, and combinations of discounts, credits, rate differentials, or reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm can be or have been installed or implemented. The prescribed form shall describe generally what actions the policyholders may be able to take to reduce their windstorm premium. The prescribed form and a list of such ranges approved by the office for each insurer licensed in the state and providing such discounts, credits, other rate differentials, or reductions in deductibles for properties described in this subsection shall be available for electronic viewing and download from the Department of Financial Services' or the Office of Insurance Regulation's Internet website. The Financial Services Commission may adopt rules to implement this subsection.

(2)(a) The Financial Services Commission shall develop by rule a uniform mitigation verification inspection form that shall be used by all insurers when submitted by policyholders for the purpose of factoring discounts for wind insurance. In developing the form, the commission shall seek input from insurance, construction, and building code representatives. Further, the commission shall provide guidance as to the length of time the inspection results are valid. An insurer shall accept as valid a uniform mitigation verification form signed by the following authorized mitigation inspectors:

1. A home inspector licensed under s. 468.8314 who has completed at least 3 hours of hurricane mitigation training approved by the Construction Industry Licensing Board which includes hurricane mitigation techniques and compliance with the uniform mitigation verification form and completion of a proficiency exam;
2. A building code inspector certified under s. 468.607;
3. A general, building, or residential contractor licensed under s. 489.111;
4. A professional engineer licensed under s. 471.015;
5. A professional architect licensed under s. 481.213; or
6. Any other individual or entity recognized by the insurer as possessing the necessary qualifications to properly complete a uniform mitigation verification form.

(b) An insurer may, but is not required to, accept a form from any other person possessing qualifications and experience acceptable to the insurer.

(3) A person who is authorized to sign a mitigation verification form must inspect the structures referenced by the form personally, not through employees or other persons, and must certify or attest to personal inspection of the structures referenced by the form. However, licensees under s. 471.015 or s. 489.111 may authorize a direct employee, who is not an independent contractor, and who possesses the requisite skill, knowledge and experience, to conduct a mitigation verification inspection. Insurers shall have the right to request and obtain information from the authorized mitigation inspector under s. 471.015 or s. 489.111, regarding any authorized employee's qualifications prior to accepting a mitigation verification form performed by an employee that is not licensed under s. 471.015 or s. 489.111.

(4) An authorized mitigation inspector that signs a uniform mitigation form, and a direct employee authorized to conduct mitigation verification inspections under paragraph (3), may not commit misconduct in performing hurricane mitigation inspections or in completing a uniform mitigation form that causes financial harm to a customer or their insurer; or that

jeopardizes a customer's health and safety. Misconduct occurs when an authorized mitigation inspector signs a uniform mitigation verification form that:

(a) Falsely indicates that he or she personally inspected the structures referenced by the form;

(b) Falsely indicates the existence of a feature which entitles an insured to a mitigation discount which the inspector knows does not exist or did not personally inspect;

(c) Contains erroneous information due to the gross negligence of the inspector; or

(d) Contains a pattern of demonstrably false information regarding the existence of mitigation features that could give an insured a false evaluation of the ability of the structure to withstand major damage from a hurricane endangering the safety of the insured's life and property.

(5) The licensing board of an authorized mitigation inspector that violates subsection (4) may commence disciplinary proceedings and impose administrative fines and other sanctions authorized under the authorized mitigation inspector's licensing act. Authorized mitigation inspectors licensed under s. 471.015 or s. 489.111 shall be directly liable for the acts of employees that violate subsection (4) as if the authorized mitigation inspector personally performed the inspection.

(6) An insurer, person, or other entity that obtains evidence of fraud or evidence that an authorized mitigation inspector or an employee authorized to conduct mitigation verification inspections under paragraph (3) has made false statements in the completion of a mitigation inspection form shall file a report with the Division of Insurance Fraud, along with all of the evidence in its possession that supports the allegation of fraud or falsity. An insurer, person, or other entity making the report shall be immune from liability, in accordance with s. 626.989(4), for any statements made in the report, during the investigation, or in connection with the report. The Division of Insurance Fraud shall issue an investigative report if it finds that probable cause exists to believe that the authorized mitigation inspector, or an employee authorized to conduct mitigation verification inspections under paragraph (3), made intentionally false or fraudulent statements in the inspection form. Upon conclusion of the investigation and a finding of probable cause that a violation has occurred, the Division of Insurance Fraud shall send a copy of the investigative report to the office and a copy to the agency responsible for the professional licensure of the authorized mitigation inspector, whether or not a prosecutor takes action based upon the report.

(7) An individual or entity who knowingly provides or utters a false or fraudulent mitigation verification form with the intent to obtain or receive a discount on an insurance premium to which the individual or entity is not entitled commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(8) At its expense, the insurer may require that a uniform mitigation verification form provided by a policyholder, a policyholder's agent, or an authorized mitigation inspector or inspection company be independently verified by an inspector, an inspection company, or an independent third-party quality assurance provider which possesses a quality assurance program before accepting the uniform mitigation verification form as valid.

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) Medical benefits.—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and

medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner licensed under chapter 464. Followup services and care may also be provided by any of the following persons or entities:

a. A hospital or ambulatory surgical center licensed under chapter 395.

b. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

c. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in this subparagraph.

e. A health care clinic licensed under part X of chapter 400 which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc., or

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to $10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to $2,500 if any provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage or

acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.

(b) Disability benefits.—Sixty percent of any loss of gross income and loss of earning capacity per individual from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision must be paid at least every 2 weeks.

(c) Death benefits.—Death benefits of $5,000 per individual. Death benefits are in addition to the medical and disability benefits provided under the insurance policy. The insurer may pay death benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood, legal adoption, or marriage, or to any person appearing to the insurer to be equitably entitled to such benefits.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

(2) AUTHORIZED EXCLUSIONS.—Any insurer may exclude benefits:

(a) For injury sustained by the named insured and relatives residing in the same household while occupying another motor vehicle owned by the named insured and not insured under the policy or for injury sustained by any person operating the insured motor vehicle without the express or implied consent of the insured.

(b) To any injured person, if such person's conduct contributed to his or her injury under any of the following circumstances:

1. Causing injury to himself or herself intentionally; or
2. Being injured while committing a felony.

Whenever an insured is charged with conduct as set forth in subparagraph 2., the 30-day payment provision of paragraph (4)(b) shall be held in abeyance, and the insurer shall withhold payment of any personal injury protection benefits pending the outcome of the case at the trial level. If the charge is nolle prossed or dismissed or the insured is acquitted, the 30-day payment provision shall run from the date the insurer is notified of such action.

(3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN TORT CLAIMS.—No insurer shall have a lien on any recovery in tort by judgment, settlement, or otherwise for personal injury protection benefits, whether suit has been filed or settlement has been reached without suit. An injured party who is entitled to bring suit under the provisions of ss. 627.730-627.7405, or his or her legal representative, shall have no right to recover any damages for which personal injury protection benefits are paid or payable. The plaintiff may prove all of his or her special damages notwithstanding this limitation, but if special

damages are introduced in evidence, the trier of facts, whether judge or jury, shall not award damages for personal injury protection benefits paid or payable. In all cases in which a jury is required to fix damages, the court shall instruct the jury that the plaintiff shall not recover such special damages for personal injury protection benefits paid or payable.

(4) PAYMENT OF BENEFITS.—Benefits due from an insurer under ss. 627.730-627.7405 are primary, except that benefits received under any workers' compensation law must be credited against the benefits provided by subsection (1) and are due and payable as loss accrues upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. If the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, the benefits under ss. 627.730-627.7405 are subject to the Medicaid program. However, within 30 days after receiving notice that the Medicaid program paid such benefits, the insurer shall repay the full amount of the benefits to the Medicaid program.

(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by ss. 627.730-627.7405.

(b) Personal injury protection insurance benefits paid pursuant to this section are overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. However:

1. If written notice of the entire claim is not furnished to the insurer, any partial amount supported by written notice is overdue if not paid within 30 days after written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after written notice is furnished to the insurer.

2. If an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge if this does not limit the introduction of evidence at trial. The insurer must also include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence.

3. If an insurer pays only a portion of a claim or rejects a claim due to an alleged error in the claim, the insurer, at the time of the partial payment or rejection, shall provide an itemized specification or explanation of benefits due to the specified error. Upon receiving the specification or explanation, the person making the claim, at the person's option and without waiving any other legal remedy for payment, has 15 days to submit a revised claim, which shall be considered a timely submission of written notice of a claim.

4. Notwithstanding the fact that written notice has been furnished to the insurer, payment is not overdue if the insurer has reasonable proof that the insurer is not responsible for the payment.

5. For the purpose of calculating the extent to which benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.

6. This paragraph does not preclude or limit the ability of the insurer to assert that the claim was unrelated, was not medically necessary, or was unreasonable or that the amount of the charge was in excess of that permitted under, or in violation of, subsection (5). Such assertion may be made at any time, including after payment of the claim or after the 30-day period for payment set forth in this paragraph.

(c) Upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002, or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of such claims may be used by the insurer to pay other claims. The time periods specified in paragraph (b) for payment of personal injury protection benefits are tolled for the period of time that an insurer is required to hold payment of a claim that is not from such physician or dentist to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

(d) All overdue payments bear simple interest at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, for the quarter in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of covered loss. Interest is due at the time payment of the overdue claim is made.

(e) The insurer of the owner of a motor vehicle shall pay personal injury protection benefits for:

1. Accidental bodily injury sustained in this state by the owner while occupying a motor vehicle, or while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with a motor vehicle.

2. Accidental bodily injury sustained outside this state, but within the United States of America or its territories or possessions or Canada, by the owner while occupying the owner's motor vehicle.

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2., if the relative at the time of the accident is domiciled in the owner's household and is not the owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405.

4. Accidental bodily injury sustained in this state by any other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with such motor vehicle, if the injured person is not:

a. The owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405; or

b. Entitled to personal injury benefits from the insurer of the owner of such a motor vehicle.

(f) If two or more insurers are liable for paying personal injury protection benefits for the same injury to any one person, the maximum payable is as specified in subsection (1), and the insurer paying the benefits is entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.

(g) It is a violation of the insurance code for an insurer to fail to timely provide benefits as required by this section with such frequency as to constitute a general business practice.

(h) Benefits are not due or payable to or on the behalf of an insured person if that person has committed, by a material act or omission, insurance fraud relating to personal injury protection coverage under his or her policy, if the fraud is admitted to in a sworn statement by the insured or established in a court of competent jurisdiction. Any insurance fraud voids all coverage arising from the claim related to such fraud under the personal injury protection coverage of the insured person who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid before the

discovery of the fraud is recoverable by the insurer in its entirety from the person who committed insurance fraud. The prevailing party is entitled to its costs and attorney fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph.

(i) If an insurer has a reasonable belief that a fraudulent insurance act, for the purposes of s. 626.989 or s. 817.234, has been committed, the insurer shall notify the claimant, in writing, within 30 days after submission of the claim that the claim is being investigated for suspected fraud. Beginning at the end of the initial 30-day period, the insurer has an additional 60 days to conduct its fraud investigation. Notwithstanding subsection (10), no later than 90 days after the submission of the claim, the insurer must deny the claim or pay the claim with simple interest as provided in paragraph (d). Interest shall be assessed from the day the claim was submitted until the day the claim is paid. All claims denied for suspected fraudulent insurance acts shall be reported to the Division of Insurance Fraud.

(j) An insurer shall create and maintain for each insured a log of personal injury protection benefits paid by the insurer on behalf of the insured. If litigation is commenced, the insurer shall provide to the insured a copy of the log within 30 days after receiving a request for the log from the insured.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a) A physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. However, such a charge may not exceed the amount the person or institution customarily charges for like services or supplies. In determining whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

1. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002 provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under:

(I) The participating physicians fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

However, if such services, supplies, or care is not reimbursable under Medicare Part B, as provided in this sub-subparagraph, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

2. For purposes of subparagraph 1., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the year in which the services, supplies, or care is rendered and for the area in which such services, supplies, or care is rendered, and the applicable fee schedule or payment limitation applies throughout the remainder of that year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

3. Subparagraph 1. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes. However, subparagraph 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

4. If an insurer limits payment as authorized by subparagraph 1., the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.

5. Effective July 1, 2012, an insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

(b)1. An insurer or insured is not required to pay a claim or charges:

a. Made by a broker or by a person making a claim on behalf of a broker;

b. For any service or treatment that was not lawful at the time rendered;

c. To any person who knowingly submits a false or misleading statement relating to the claim or charges;

d. With respect to a bill or statement that does not substantially meet the applicable requirements of paragraph (d);

e. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines have been

improperly or incorrectly upcoded or unbundled and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, if, before doing so, the insurer contacts the health care provider and discusses the reasons for the insurer's change and the health care provider's reason for the coding, or makes a reasonable good faith effort to do so, as documented in the insurer's file; and

f. For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.

2. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits under this section. The list shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and may not be dependent for results entirely upon subjective patient response. Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for an invalid diagnostic test as determined by the Department of Health.

(c) With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services and care as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider may not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

1. If the insured fails to furnish the provider with the correct name and address of the insured's personal injury protection insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of the charges. The insurer is not required to pay for such charges unless the provider includes with the statement documentary evidence that was provided by the insured during the 35-day period demonstrating that the provider reasonably relied on erroneous information from the insured and either:

a. A denial letter from the incorrect insurer; or

b. Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.

2. For emergency services and care rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph, and the insurer is not considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph (d), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the federal Centers for Medicare and Medicaid Services.

3. Each notice of the insured's rights under s. 627.7401 must include the following statement in at least 12-point type:

BILLING REQUIREMENTS.—Florida law provides that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

(d) All statements and bills for medical services rendered by a physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers must, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the CMS 1500 form instructions, the American Medical Association CPT Editorial Panel, and the HCPCS. All providers, other than hospitals, must include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General, Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. A statement of medical services may not include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer is not considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph and are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

(e)1. At the initial treatment or service provided, each physician, other licensed professional, clinic, or other medical institution providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:

a. The insured, or his or her guardian, must countersign the form attesting to the fact that the services set forth therein were actually rendered;

b. The insured, or his or her guardian, has both the right and affirmative duty to confirm that the services were actually rendered;

c. The insured, or his or her guardian, was not solicited by any person to seek any services from the medical provider;

d. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed explained the services to the insured or his or her guardian; and

e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services

rendered to the insured, or his or her guardian, so that the insured, or his or her guardian, countersigns the form with informed consent.

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or other services that are of such a nature that they are not required to be performed in the presence of the insured.

4. The licensed medical professional rendering treatment for which payment is being claimed must sign, by his or her own hand, the form complying with this paragraph.

5. The original completed disclosure and acknowledgment form shall be furnished to the insurer pursuant to paragraph (4)(b) and may not be electronically furnished.

6. The disclosure and acknowledgment form is not required for services billed by a provider for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.

7. The Financial Services Commission shall adopt, by rule, a standard disclosure and acknowledgment form to be used to fulfill the requirements of this paragraph.

8. As used in this paragraph, the term "countersign" or "countersignature" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement.

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, which is consistent with the services being rendered to the patient as claimed. The requirement to maintain a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

(f) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine if the insured was properly billed for only those services and treatments that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured, the person making the written notification, and the provider of its findings and reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to a written notification by any person, the insurer shall pay to the person 20 percent of the amount of the reduction, up to $500. If the provider is arrested due to the improper billing, the insurer shall pay to the person 40 percent of the amount of the reduction, up to $500.

(g) An insurer may not systematically downcode with the intent to deny reimbursement otherwise due. Such action constitutes a material misrepresentation under s. 626.9541(1)(i)2.

(h) As provided in s. 400.9905, an entity excluded from the definition of a clinic shall be deemed a clinic and must be licensed under part X of chapter 400 in order to receive reimbursement under ss. 627.730-627.7405. However, this licensing requirement does not apply to:

1. An entity wholly owned by a physician licensed under chapter 458 or chapter 459, or by the physician and the spouse, parent, child, or sibling of the physician;

2. An entity wholly owned by a dentist licensed under chapter 466, or by the dentist and the spouse, parent, child, or sibling of the dentist;

3. An entity wholly owned by a chiropractic physician licensed under chapter 460, or by the chiropractic physician and the spouse, parent, child, or sibling of the chiropractic physician;

4. A hospital or ambulatory surgical center licensed under chapter 395;

5. An entity that wholly owns or is wholly owned, directly or indirectly, by a hospital or hospitals licensed under chapter 395; or

6. An entity that is a clinical facility affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

(6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.—
(a) If a request is made by an insurer providing personal injury protection benefits under ss. 627.730-627.7405 against whom a claim has been made, an employer must furnish, in a form approved by the office, a sworn statement of the earnings, since the time of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.
(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested by the insurer against whom the claim has been made, furnish a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce, and allow the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment if this does not limit the introduction of evidence at trial. Such sworn statement must read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." A cause of action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought against any physician, hospital, clinic, or other medical institution complying with this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount that is the subject of the insurer's inquiry is overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. As used in this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. An insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.
(c) In the event of a dispute regarding an insurer's right to discovery of facts under this section, the insurer may petition a court of competent jurisdiction to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and must specify the time, place, manner, conditions, and scope of the discovery. In order to protect against annoyance, embarrassment, or oppression, as justice requires, the court may enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.
(d) The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under this section, and pay a reasonable charge, if required by the insurer.
(e) Notice to an insurer of the existence of a claim may not be unreasonably withheld by an insured.
(f) In a dispute between the insured and the insurer, or between an assignee of the insured's rights and the insurer, upon request, the insurer must notify the insured or the assignee that the policy limits under this section have been reached within 15 days after the limits have been reached.

(g) An insured seeking benefits under ss. 627.730–627.7405, including an omnibus insured, must comply with the terms of the policy, which include, but are not limited to, submitting to an examination under oath. The scope of questioning during the examination under oath is limited to relevant information or information that could reasonably be expected to lead to relevant information. Compliance with this paragraph is a condition precedent to receiving benefits. An insurer that, as a general business practice as determined by the office, requests an examination under oath of an insured or an omnibus insured without a reasonable basis is subject to s. 626.9541.

(7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.—

(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides, or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a valid report by a Florida physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary. A valid report is one that is prepared and signed by the physician examining the injured person or reviewing the treatment records of the injured person and is factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that during the 3 years immediately preceding the date of the physical examination or review of the treatment records the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions or to the instruction of students in an accredited health professional school or accredited residency program or a clinical research program that is affiliated with an accredited health professional school or teaching hospital or accredited residency program. The physician preparing a report at the request of an insurer and physicians rendering expert opinions on behalf of persons claiming medical benefits for personal injury protection, or on behalf of an insured through an attorney or another entity, shall maintain, for at least 3 years, copies of all examination reports as medical records and shall maintain, for at least 3 years, records of all payments for the examinations and reports. Neither an insurer nor any person acting at the direction of or on behalf of an insurer may materially change an opinion in a report prepared under this paragraph or direct the physician preparing the report to change such opinion. The denial of a payment as the result of such a changed opinion constitutes a material misrepresentation under s. 626.9541(1)(i)2.; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file.

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by

an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit to or fails to appear at an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits. An insured's refusal to submit to or failure to appear at two examinations raises a rebuttable presumption that the insured's refusal or failure was unreasonable.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY FEES.—With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, the provisions of ss. 627.428 and 768.79 apply, except as provided in subsections (10) and (15), and except that any attorney fees recovered must:

(a) Comply with prevailing professional standards;

(b) Not overstate or inflate the number of hours reasonably necessary for a case of comparable skill or complexity; and

(c) Represent legal services that are reasonable and necessary to achieve the result obtained.

Upon request by either party, a judge must make written findings, substantiated by evidence presented at trial or any hearings associated therewith, that any award of attorney fees complies with this subsection. Notwithstanding s. 627.428, attorney fees recovered under ss. 627.730-627.7405 must be calculated without regard to a contingency risk multiplier.

(9) PREFERRED PROVIDERS.—An insurer may negotiate and contract with preferred providers for the benefits described in this section, which include health care providers licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchasing the policy for personal injury protection benefits, if the requirements of this subsection are met. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer shall provide each insured with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the insurer's principal office within the state.

(10) DEMAND LETTER.—

(a) As a condition precedent to filing any action for benefits under this section, written notice of an intent to initiate litigation must be provided to the insurer. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b).

(b) The notice must state that it is a "demand letter under s. 627.736" and state with specificity:

1. The name of the insured upon which such benefits are being sought, including a copy of the assignment giving rights to the claimant if the claimant is not the insured.
2. The claim number or policy number upon which such claim was originally submitted to the insurer.
3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (5)(d) or the lost-wage statement previously submitted may be used as the itemized statement. To the extent that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.

(c) Each notice required by this subsection must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs shall be reimbursed by the insurer if requested by the claimant in the notice, when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office the name and address of the designated person to whom notices must be sent which the office shall make available on its Internet website. The name and address on file with the office pursuant to s. 624.422 is deemed the authorized representative to accept notice pursuant to this subsection if no other designation has been made.

(d) If, within 30 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, no action may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, no action may be brought against the insurer if, within 30 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section. To the extent the insurer determines not to pay any amount demanded, the penalty is not payable in any subsequent action. For purposes of this subsection, payment or the insurer's agreement shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer is not obligated to pay any attorney fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

(e) The applicable statute of limitation for an action under this section shall be tolled for 30 business days by the mailing of the notice required by this subsection.

(11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE PRACTICE.—

(a) An insurer is engaging in a prohibited unfair or deceptive practice that is subject to the penalties provided in s. 626.9521 and the office has the powers and duties specified in ss. 626.9561-626.9601 if the insurer, with such frequency so as to indicate a general business practice:

1. Fails to pay valid claims for personal injury protection; or
2. Fails to pay valid claims until receipt of the notice required by subsection (10).

(b) Notwithstanding s. 501.212, the Department of Legal Affairs may investigate and initiate actions for a violation of this subsection, including, but not limited to, the powers and duties specified in part II of chapter 501.

(12) CIVIL ACTION FOR INSURANCE FRAUD.—An insurer shall have a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section. An insurer prevailing in an action brought under this subsection may recover compensatory, consequential, and punitive damages subject to the requirements and limitations of part II of chapter 768, and attorney's fees and costs incurred in litigating a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section.

(13) MINIMUM BENEFIT COVERAGE.—If the Financial Services Commission determines that the cost savings under personal injury protection insurance benefits paid by insurers have been realized due to the provisions of this act, prior legislative reforms, or other factors, the commission may increase the minimum $10,000 benefit coverage requirement. In establishing the amount of such increase, the commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized for the personal injury protection coverage with limits of $10,000.

(14) FRAUD ADVISORY NOTICE.—Upon receiving notice of a claim under this section, an insurer shall provide a notice to the insured or to a person for whom a claim for reimbursement for diagnosis or treatment of injuries has been filed, advising that:

(a) Pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

(b) Solicitation of a person injured in a motor vehicle crash for purposes of filing personal injury protection or tort claims could be a violation of s. 817.234, s. 817.505, or the rules regulating The Florida Bar and should be immediately reported to the Division of Insurance Fraud if such conduct has taken place.

(15) ALL CLAIMS BROUGHT IN A SINGLE ACTION.—In any civil action to recover personal injury protection benefits brought by a claimant pursuant to this section against an insurer, all claims related to the same health care provider for the same injured person shall be brought in one action, unless good cause is shown why such claims should be brought separately. If the court determines that a civil action is filed for a claim that should have been brought in a prior civil action, the court may not award attorney's fees to the claimant.

(16) SECURE ELECTRONIC DATA TRANSFER.—A notice, documentation, transmission, or communication of any kind required or authorized under ss. 627.730-627.7405 may be transmitted electronically if it is transmitted by secure electronic data transfer that is consistent with state and federal privacy and security laws.

(17) NONREIMBURSIBLE CLAIMS.—Claims generated as a result of activities that are unlawful pursuant to s. 817.505 are not reimbursable under the Florida Motor Vehicle No-Fault Law.

215.5586 My Safe Florida Home Program.—There is established within the Department of Financial Services the My Safe Florida Home Program. The department shall provide fiscal accountability, contract management, and strategic leadership for the program, consistent with this section. This section does not create an entitlement for property owners or obligate the state in any way to fund the inspection or retrofitting of residential property in this state. Implementation of this program is subject to annual legislative appropriations. It is the intent of the Legislature that the My Safe Florida Home Program provide trained and certified inspectors to perform inspections for owners of site-built, single-family, residential properties and grants to eligible applicants as funding allows. The program shall develop and implement a comprehensive and coordinated approach for hurricane damage mitigation that may include the following:

(1) HURRICANE MITIGATION INSPECTIONS.—

(a) Certified inspectors to provide home-retrofit inspections of site-built, single-family, residential property may be offered to determine what mitigation measures are needed, what insurance premium discounts may be available, and what improvements to existing residential properties are needed to reduce the property's vulnerability to hurricane damage. The Department of Financial Services shall contract with wind certification entities to provide hurricane mitigation inspections. The inspections provided to homeowners, at a minimum, must include:

1. A home inspection and report that summarizes the results and identifies recommended improvements a homeowner may take to mitigate hurricane damage.

2. A range of cost estimates regarding the recommended mitigation improvements.

3. Insurer-specific information regarding premium discounts correlated to the current mitigation features and the recommended mitigation improvements identified by the inspection.

(b) To qualify for selection by the department as a wind certification entity to provide hurricane mitigation inspections, the entity shall, at a minimum, meet the following requirements:

1. Use hurricane mitigation inspectors who:

a. Are certified as a building inspector under s. 468.607;

b. Are licensed as a general or residential contractor under s. 489.111;

c. Are licensed as a professional engineer under s. 471.015 and who have passed the appropriate equivalency test of the building code training program as required by s. 553.841;

d. Are licensed as a professional architect under s. 481.213; or

e. Have at least 2 years of experience in residential construction or residential building inspection and have received specialized training in hurricane mitigation procedures. Such training may be provided by a class offered online or in person.

2. Use hurricane mitigation inspectors who also:

a. Have undergone drug testing and a background screening. The department may conduct criminal record checks of inspectors used by wind certification entities. Inspectors must submit a set of the fingerprints to the department for state and national criminal history checks and must pay the fingerprint processing fee set forth in s. 624.501. The fingerprints shall be sent by the department to the Department of Law Enforcement and forwarded to the Federal Bureau of Investigation for processing. The results shall be returned to the department for screening. The fingerprints shall be taken by a law enforcement agency, designated examination center, or other department-approved entity; and

b. Have been certified, in a manner satisfactory to the department, to conduct the inspections.

3. Provide a quality assurance program including a reinspection component.

(c) The department shall implement a quality assurance program that includes a statistically valid number of reinspections.

(d) An application for an inspection must contain a signed or electronically verified statement made under penalty of perjury that the applicant has submitted only a single application for that home.

(e) The owner of a site-built, single-family, residential property may apply for and receive an inspection without also applying for a grant pursuant to subsection (2) and without meeting the requirements of paragraph (2)(a).

(2) MITIGATION GRANTS.—Financial grants shall be used to encourage single-family, site-built, owner-occupied, residential property owners to retrofit their properties to make them less vulnerable to hurricane damage.

(a) For a homeowner to be eligible for a grant, the following criteria must be met:

1. The homeowner must have been granted a homestead exemption on the home under chapter 196.
2. The home must be a dwelling with an insured value of $300,000 or less. Homeowners who are low-income persons, as defined in s. 420.0004(11), are exempt from this requirement.
3. The home must have undergone an acceptable hurricane mitigation inspection after May 1, 2007.
4. The home must be located in the "wind-borne debris region" as that term is defined in s. 1609.2, International Building Code (2006), or as subsequently amended.
5. The building permit application for initial construction of the home must have been made before March 1, 2002.

An application for a grant must contain a signed or electronically verified statement made under penalty of perjury that the applicant has submitted only a single application and must have attached documents demonstrating the applicant meets the requirements of this paragraph.

(b) All grants must be matched on a dollar-for-dollar basis up to a total of $10,000 for the actual cost of the mitigation project with the state's contribution not to exceed $5,000.

(c) The program shall create a process in which contractors agree to participate and homeowners select from a list of participating contractors. All mitigation must be based upon the securing of all required local permits and inspections and must be performed by properly licensed contractors. Mitigation projects are subject to random reinspection of up to at least 5 percent of all projects. Hurricane mitigation inspectors qualifying for the program may also participate as mitigation contractors as long as the inspectors meet the department's qualifications and certification requirements for mitigation contractors.

(d) Matching fund grants shall also be made available to local governments and nonprofit entities for projects that will reduce hurricane damage to single-family, site-built, owner-occupied, residential property. The department shall liberally construe those requirements in favor of availing the state of the opportunity to leverage funding for the My Safe Florida Home Program with other sources of funding.

(e) When recommended by a hurricane mitigation inspection, grants may be used for the following improvements:

1. Opening protection.
2. Exterior doors, including garage doors.
3. Brace gable ends.
4. Reinforcing roof-to-wall connections.
5. Improving the strength of roof-deck attachments.
6. Upgrading roof covering from code to code plus.
7. Secondary water barrier for roof.

The department may require that improvements be made to all openings, including exterior doors and garage doors, as a condition of reimbursing a homeowner approved for a grant. The department may adopt, by rule, the maximum grant allowances for any improvement allowable under this paragraph.

(f) Grants may be used on a previously inspected existing structure or on a rebuild. A rebuild is defined as a site-built, single-family dwelling under construction to replace a home that was destroyed or significantly damaged by a hurricane and deemed unlivable by a regulatory authority. The homeowner must be a low-income homeowner as defined in paragraph (g), must have had a homestead exemption for that home prior to the hurricane, and must be intending to rebuild the home as that homeowner's homestead.

(g) Low-income homeowners, as defined in s. 420.0004(11), who otherwise meet the requirements of paragraphs (a), (c), (e), and (f) are eligible for a grant of up to $5,000 and

are not required to provide a matching amount to receive the grant. Additionally, for low-income homeowners, grant funding may be used for repair to existing structures leading to any of the mitigation improvements provided in paragraph (e), limited to 20 percent of the grant value. The program may accept a certification directly from a low-income homeowner that the homeowner meets the requirements of s. 420.0004(11) if the homeowner provides such certification in a signed or electronically verified statement made under penalty of perjury.

(h) The department shall establish objective, reasonable criteria for prioritizing grant applications, consistent with the requirements of this section.

(i) The department shall develop a process that ensures the most efficient means to collect and verify grant applications to determine eligibility and may direct hurricane mitigation inspectors to collect and verify grant application information or use the Internet or other electronic means to collect information and determine eligibility.

(3) EDUCATION AND CONSUMER AWARENESS.—The department may undertake a statewide multimedia public outreach and advertising campaign to inform consumers of the availability and benefits of hurricane inspections and of the safety and financial benefits of residential hurricane damage mitigation. The department may seek out and use local, state, federal, and private funds to support the campaign.

(4) ADVISORY COUNCIL.—There is created an advisory council to provide advice and assistance to the department regarding administration of the program. The advisory council shall consist of:

(a) A representative of lending institutions, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Bankers Association.

(b) A representative of residential property insurers, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Insurance Council.

(c) A representative of home builders, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Home Builders Association.

(d) A faculty member of a state university, selected by the Financial Services Commission, who is an expert in hurricane-resistant construction methodologies and materials.

(e) Two members of the House of Representatives, selected by the Speaker of the House of Representatives.

(f) Two members of the Senate, selected by the President of the Senate.

(g) The Chief Executive Officer of the Federal Alliance for Safe Homes, Inc., or his or her designee.

(h) The senior officer of the Florida Hurricane Catastrophe Fund.

(i) The executive director of Citizens Property Insurance Corporation.

(j) The director of the Florida Division of Emergency Management.

Members appointed under paragraphs (a)-(d) shall serve at the pleasure of the Financial Services Commission. Members appointed under paragraphs (e) and (f) shall serve at the pleasure of the appointing officer. All other members shall serve as voting ex officio members. Members of the advisory council shall serve without compensation but may receive reimbursement as provided in s. 112.061 for per diem and travel expenses incurred in the performance of their official duties.

(5) FUNDING.—The department may seek out and leverage local, state, federal, or private funds to enhance the financial resources of the program.

(6) RULES.—The Department of Financial Services shall adopt rules pursuant to ss. 120.536(1) and 120.54 to govern the program; implement the provisions of this section; including rules governing hurricane mitigation inspections and grants, mitigation contractors, and training of inspectors and contractors; and carry out the duties of the department under this section.

(7) HURRICANE MITIGATION INSPECTOR LIST.—The department shall develop and maintain as a public record a current list of hurricane mitigation inspectors authorized to conduct hurricane mitigation inspections pursuant to this section.

(8) PUBLIC OUTREACH FOR CONTRACTORS AND REAL ESTATE BROKERS AND SALES ASSOCIATES.—The program shall develop brochures for distribution to general contractors, roofing contractors, and real estate brokers and sales associates licensed under part I of chapter 475 explaining the benefits to homeowners of residential hurricane damage mitigation. The program shall encourage contractors to distribute the brochures to homeowners at the first meeting with a homeowner who is considering contracting for home or roof repairs or contracting for the construction of a new home. The program shall encourage real estate brokers and sales associates licensed under part I of chapter 475 to distribute the brochures to clients prior to the purchase of a home. The brochures may be made available electronically.

(9) CONTRACT MANAGEMENT.—The department may contract with third parties for grants management, inspection services, contractor services for low-income homeowners, information technology, educational outreach, and auditing services. Such contracts shall be considered direct costs of the program and shall not be subject to administrative cost limits, but contracts valued at $1 million or more shall be subject to review and approval by the Legislative Budget Commission. The department shall contract with providers that have a demonstrated record of successful business operations in areas directly related to the services to be provided and shall ensure the highest accountability for use of state funds, consistent with this section.

(10) INTENT.—It is the intent of the Legislature that grants made to residential property owners under this section shall be considered disaster-relief assistance within the meaning of s. 139 of the Internal Revenue Code of 1986, as amended.

(11) REPORTS.—The department shall make an annual report on the activities of the program that shall account for the use of state funds and indicate the number of inspections requested, the number of inspections performed, the number of grant applications received, and the number and value of grants approved. The report shall be delivered to the President of the Senate and the Speaker of the House of Representatives by February 1 of each year.

624.307 General powers; duties.—

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

624.424 Annual statement and other information.—

(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing 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.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must

submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to implement this subsection, which rules must be in substantial conformity with the 1998 Model Rule Requiring Annual Audited Financial Reports adopted by the National Association of Insurance Commissioners or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. No insurer may raise as a defense in any action, any exception to, waiver of, or interpretation of accounting requirements, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.

627.062 Rate standards.—

(1) The rates for all classes of insurance to which the provisions of this part are applicable may not be excessive, inadequate, or unfairly discriminatory.

(2) As to all such classes of insurance:

(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals that allow the insurer a reasonable rate of return on the classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, must be filed with the office under one of the following procedures:

1. If the filing is made at least 90 days before the proposed effective date and is not implemented during the office's review of the filing and any proceeding and judicial review, such filing is considered a "file and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings does not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.

2. If the filing is not made in accordance with subparagraph 1., such filing must be made as soon as practicable, but within 30 days after the effective date, and is considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders those portions of rates found to be excessive, as provided in paragraph (h).

3. For all property insurance filings made or submitted after January 25, 2007, but before May 1, 2012, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered property coverages.

(b) Upon receiving a rate filing, the office shall review the filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:

1. Past and prospective loss experience within and without this state.
2. Past and prospective expenses.
3. The degree of competition among insurers for the risk insured.
4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers calculate investment income attributable to classes of insurance written in this state and the manner in which investment income is used to calculate insurance rates. Such

manner must contemplate allowances for an underwriting profit factor and full consideration of investment income which produce a reasonable rate of return; however, investment income from invested surplus may not be considered.

5. The reasonableness of the judgment reflected in the filing.

6. Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.

7. The adequacy of loss reserves.

8. The cost of reinsurance. The office may not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer's estimated 250-year probable maximum loss or any lower level of loss.

9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

10. Conflagration and catastrophe hazards, if applicable.

11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.

12. A reasonable margin for underwriting profit and contingencies.

13. The cost of medical services, if applicable.

14. Other relevant factors that affect the frequency or severity of claims or expenses.

(c) In the case of fire insurance rates, consideration must be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.

(d) If conflagration or catastrophe hazards are considered by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and maintain the premium in a catastrophe reserve. Removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes must be approved by the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes must be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), the office may find a rate to be excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business which is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.

2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, if the replenishment is attributable to investment losses.

3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625.

5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.

6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.

(f) In reviewing a rate filing, the office may require the insurer to provide, at the insurer's expense, all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.

(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being notified, the insurer or rating organization shall, within 60 days, file with the office all information that, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer may not alter the rate except to conform to the office's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of implementing the rate. The office, subject to chapter 120, may disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(h) If the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule, which responds to the findings of the office, be filed by the insurer. The office shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to the policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding is applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(i) Except as otherwise specifically provided in this chapter, for property and casualty insurance the office may not directly or indirectly:

1. Prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing; or

2. Impede, abridge, or otherwise compromise an insurer's right to acquire policyholders, advertise, or appoint agents, including the calculation, manner, or amount of such agent commissions, if any.

(j) With respect to residential property insurance rate filings, the rate filing must account for mitigation measures undertaken by policyholders to reduce hurricane losses.

(k)1. A residential property insurer may make a separate filing limited solely to an adjustment of its rates for reinsurance, the cost of financing products used as a replacement for reinsurance, financing costs incurred in the purchase of reinsurance, and the actual cost paid due to the application of the cash build-up factor pursuant to s. 215.555(5)(b) if the insurer:

a. Elects to purchase financing products such as a liquidity instrument or line of credit, in which case the cost included in filing for the liquidity instrument or line of credit may not result in a premium increase exceeding 3 percent for any individual policyholder. All costs

contained in the filing may not result in an overall premium increase of more than 15 percent for any individual policyholder.

b. Includes in the filing a copy of all of its reinsurance, liquidity instrument, or line of credit contracts; proof of the billing or payment for the contracts; and the calculation upon which the proposed rate change is based demonstrating that the costs meet the criteria of this section.

2. An insurer that purchases reinsurance or financing products from an affiliated company may make a separate filing only if the costs for such reinsurance or financing products are charged at or below charges made for comparable coverage by nonaffiliated reinsurers or financial entities making such coverage or financing products available in this state.

3. An insurer may make only one filing per 12-month period under this paragraph.

4. An insurer that elects to implement a rate change under this paragraph must file its rate filing with the office at least 45 days before the effective date of the rate change. After an insurer submits a complete filing that meets all of the requirements of this paragraph, the office has 45 days after the date of the filing to review the rate filing and determine if the rate is excessive, inadequate, or unfairly discriminatory.

The provisions of this subsection do not apply to workers' compensation, employer's liability insurance, and motor vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules filed with the office and that have been submitted to the insurer for individual rating, the insurer must maintain documentation on each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for at least 5 years after the effective date of the policy.

(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.

(c) This subsection does not apply to private passenger motor vehicle insurance.

(d)1. The following categories or kinds of insurance and types of commercial lines risks are not subject to paragraph (2)(a) or paragraph (2)(f):

a. Excess or umbrella.

b. Surety and fidelity.

c. Boiler and machinery and leakage and fire extinguishing equipment.

d. Errors and omissions.

e. Directors and officers, employment practices, fiduciary liability, and management liability.

f. Intellectual property and patent infringement liability.

g. Advertising injury and Internet liability insurance.

h. Property risks rated under a highly protected risks rating plan.

i. General liability.

j. Nonresidential property, except for collateral protection insurance as defined in s. 624.6085.

k. Nonresidential multiperil.

l. Excess property.

m. Burglary and theft.

n. Any other commercial lines categories or kinds of insurance or types of commercial lines risks that the office determines should not be subject to paragraph (2)(a) or paragraph

(2)(f) because of the existence of a competitive market for such insurance, similarity of such insurance to other categories or kinds of insurance not subject to paragraph (2)(a) or paragraph (2)(f), or to improve the general operational efficiency of the office.

2. Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on insurance and risks described in subparagraph 1. which are written in this state.

[1]3. An insurer must notify the office of any changes to rates for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the insurer, the type or kind of insurance subject to rate change, total premium written during the immediately preceding year by the insurer for the type or kind of insurance subject to the rate change, and the average statewide percentage change in rates. Underwriting files, premiums, losses, and expense statistics with regard to such insurance and risks written by an insurer must be maintained by the insurer and subject to examination by the office. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b), (c), and (d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

4. A rating organization must notify the office of any changes to loss cost for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to paragraph (2)(a) or paragraph (2)(f) must be maintained by the rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b)-(d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

(4) The establishment of any rate, rating classification, rating plan or schedule, or variation thereof in violation of part IX of chapter 626 is also in violation of this section.

(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the fund, together with reasonable costs of other reinsurance; however, except as otherwise provided in this section, the insurer may not recoup reinsurance costs that duplicate coverage provided by the fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium, and any over-recoupment must be subtracted from the following year's reimbursement premium.

(6)(a) If an insurer requests an administrative hearing pursuant to s. 120.57 related to a rate filing under this section, the director of the Division of Administrative Hearings shall expedite the hearing and assign an administrative law judge who shall commence the hearing within 30 days after the receipt of the formal request and enter a recommended order within 30 days after the hearing or within 30 days after receipt of the hearing transcript by the administrative law judge, whichever is later. Each party shall have 10 days in which to submit written exceptions to the recommended order. The office shall enter a final order within 30 days after the entry of the recommended order. The provisions of this paragraph may be waived upon stipulation of all parties.

(b) Upon entry of a final order, the insurer may request a expedited appellate review pursuant to the Florida Rules of Appellate Procedure. It is the intent of the Legislature that

the First District Court of Appeal grant an insurer's request for an expedited appellate review.

(7) The provisions of this subsection apply only to rates for medical malpractice insurance and control to the extent of any conflict with other provisions of this section.

(a) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base and used to justify a rate or rate change. Any common-law bad faith action identified as such, any portion of a settlement entered as a result of a statutory or common-law action, or any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages may not be included in the insurer's rate base and used to justify a rate or rate change.

(b) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, using loss experience solely for this state or giving greater credibility to this state's loss data after applying actuarially sound methods of assigning credibility to such data.

(c) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.

(d) The insurer must apply a discount or surcharge based on the health care provider's loss experience or establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used, and provide a copy, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.

(e) Each medical malpractice insurer must make a rate filing under this section, sworn to by at least two executive officers of the insurer, at least once each calendar year.

(8)(a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a rate filing:

1. The signing officer and actuary have reviewed the rate filing;

2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading;

3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and

4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.

(b) A signing officer or actuary who knowingly makes a false certification under this subsection commits a violation of s. 626.9541(1)(e) and is subject to the penalties under s. 626.9521.

(c) Failure to provide such certification by the officer and actuary shall result in the rate filing being disapproved without prejudice to be refiled.

(d) The certification made pursuant to paragraph (a) is not rendered false if, after making the subject rate filing, the insurer provides the office with additional or supplementary information pursuant to a formal or informal request from the office. However, the actuary

who is primarily responsible for preparing and submitting such information must certify the information in accordance with the certification required under paragraph (a) and the penalties in paragraph (b), except that the chief executive officer, chief financial officer, or chief actuary need not certify the additional or supplementary information.

(e) The commission may adopt rules and forms to administer this subsection.

(9) The burden is on the office to establish that rates are excessive for personal lines residential coverage with a dwelling replacement cost of $1 million or more or for a single condominium unit with a combined dwelling and contents replacement cost of $1 million or more. Upon request of the office, the insurer shall provide such loss and expense information as the office reasonably needs to meet this burden.

(10) Any interest paid pursuant to s. 627.70131(5) may not be included in the insurer's rate base and may not be used to justify a rate or rate change.

627.0629 Residential property insurance; rate filings.—

(1) It is the intent of the Legislature that insurers provide savings to consumers who install or implement windstorm damage mitigation techniques, alterations, or solutions to their properties to prevent windstorm losses. A rate filing for residential property insurance must include actuarially reasonable discounts, credits, or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. The fixtures or construction techniques must include, but are not limited to, fixtures or construction techniques that enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength. Credits, discounts, or other rate differentials, or appropriate reductions in deductibles, for fixtures and construction techniques that meet the minimum requirements of the Florida Building Code must be included in the rate filing. The office shall determine the discounts, credits, other rate differentials, and appropriate reductions in deductibles that reflect the full actuarial value of such revaluation, which may be used by insurers in rate filings.

(2)(a) A rate filing for residential property insurance made on or before the implementation of paragraph (b) may include rate factors that reflect the manner in which building code enforcement in a particular jurisdiction addresses the risk of wind damage; however, such a rate filing must also provide for variations from such rate factors on an individual basis based on an inspection of a particular structure by a licensed home inspector, which inspection may be at the cost of the insured.

(b) A rate filing for residential property insurance made more than 150 days after approval by the office of a building code rating factor plan submitted by a statewide rating organization shall include positive and negative rate factors that reflect the manner in which building code enforcement in a particular jurisdiction addresses risk of wind damage. The rate filing shall include variations from standard rate factors on an individual basis based on inspection of a particular structure by a licensed home inspector. If an inspection is requested by the insured, the insurer may require the insured to pay the reasonable cost of the inspection. This paragraph applies to structures constructed or renovated after the implementation of this paragraph.

(c) The premium notice shall specify the amount by which the rate has been adjusted as a result of this subsection and shall also specify the maximum possible positive and negative adjustments that are approved for use by the insurer under this subsection.

(3) A rate filing made on or after July 1, 1995, for mobile home owner's insurance must include appropriate discounts, credits, or other rate differentials for mobile homes constructed to comply with American Society of Civil Engineers Standard ANSI/ASCE 7-88, adopted by the United States Department of Housing and Urban Development on July 13, 1994, and that also comply with all applicable tie-down requirements provided by state law.

(4) The Legislature finds that separate consideration and notice of hurricane insurance premiums will assist consumers by providing greater assurance that hurricane premiums

are lawful and by providing more complete information regarding the components of property insurance premiums. Effective January 1, 1997, a rate filing for residential property insurance shall be separated into two components, rates for hurricane coverage and rates for all other coverages. A premium notice reflecting a rate implemented on the basis of such a filing shall separately indicate the premium for hurricane coverage and the premium for all other coverages.

(5) In order to provide an appropriate transition period, an insurer may implement an approved rate filing for residential property insurance over a period of years. Such insurer must provide an informational notice to the office setting out its schedule for implementation of the phased-in rate filing. The insurer may include in its rate the actual cost of private market reinsurance that corresponds to available coverage of the Temporary Increase in Coverage Limits, TICL, from the Florida Hurricane Catastrophe Fund. The insurer may also include the cost of reinsurance to replace the TICL reduction implemented pursuant to s. 215.555(17)(d)9. However, this cost for reinsurance may not include any expense or profit load or result in a total annual base rate increase in excess of 10 percent.

(6) Any rate filing that is based in whole or part on data from a computer model may not exceed 15 percent unless there is a public hearing.

(7) An insurer may implement appropriate discounts or other rate differentials of up to 10 percent of the annual premium to mobile home owners who provide to the insurer evidence of a current inspection of tie-downs for the mobile home, certifying that the tie-downs have been properly installed and are in good condition.

(8) A property insurance rate filing that includes any adjustments related to premiums paid to the Florida Hurricane Catastrophe Fund must include a complete calculation of the insurer's catastrophe load, and the information in the filing may not be limited solely to recovery of moneys paid to the fund.

627.0645 Annual filings.—

(1) Each rating organization filing rates for, and each insurer writing, any line of property or casualty insurance to which this part applies, except:

(a) Workers' compensation and employer's liability insurance; or

(b) Commercial property and casualty insurance as defined in s. 627.0625(1) other than commercial multiple line and commercial motor vehicle,

shall make an annual base rate filing for each such line with the office no later than 12 months after its previous base rate filing, demonstrating that its rates are not inadequate.

(2)(a) Deviations filed by an insurer to any rating organization's base rate filing are not subject to this section.

(b) The office, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(3) The filing requirements of this section shall be satisfied by one of the following methods:

(a) A rate filing prepared by an actuary which contains documentation demonstrating that the proposed rates are not excessive, inadequate, or unfairly discriminatory pursuant to the applicable rating laws and pursuant to rules of the commission.

(b) If no rate change is proposed, a filing which consists of a certification by an actuary that the existing rate level produces rates which are actuarially sound and which are not inadequate, as defined in s. 627.062.

(4) An insurer may satisfy the annual filing requirements of this section by being a member or subscriber of a licensed rating organization which complies with the requirements of this section.

(5) If an insurer does not employ or otherwise retain the services of an actuary, the insurer's rate filing or certification that rates are actuarially sound shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance ratemaking. A rate filing or certification prepared by a consultant must be reviewed and signed by an employee of the insurer who is authorized to approve rate filings.

(6) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office no later than the date the filing is due.

(7) Nothing in this section limits the office's authority to review rates at any time or to find that a rate or rate change is excessive, inadequate, or unfairly discriminatory pursuant to s. 627.062.

(8) As used in this section, the term "actuary" means an individual who is a member of the Casualty Actuarial Society.

(9) If an insurer fails to meet the filing requirements of this section and does not submit the filing within 60 days after the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for the line of insurance for which the required filing was not made until such time as the office determines that the required filing is properly submitted.

EXHIBIT D

NOTICE

FINANCIAL SERVICES COMMISSION

RULE TITLE: RULE NO.:

Emergency Adoption of Revised Notification of

Personal Injury Protection Benefits Form 69OER12-01

SPECIFIC REASONS FOR FINDING AN IMMEDIATE DANGER TO THE PUBLIC HEALTH, SAFETY OR WELFARE: The Financial Services Commission and the Office of Insurance Regulation ("Office") hereby state that the following circumstances constitute an immediate danger to the public health, safety, or welfare:

The 2012 Legislature adopted substantial amendments to the Florida No-Fault Law (Sections 627.730 – 627.7405, F.S.), hereinafter referred to as the PIP Law, which modified the personal injury protection benefits available to an insured consumer on or after January 1, 2013. Section 627.7401, F.S. requires the Financial Services Commission to adopt by rule the form that must be provided to consumers when they file a claim. The revised form will allow the timely compliance with Florida law that requires all insurers that write PIP insurance in this state to provide the consumer that has filed a claim on a policy, issued in compliance with the revised law, with proper notification of the benefits available. Requiring the utilization of the new form will prevent consumer confusion as to the new benefits that will be available pursuant to the revised PIP Law.

REASONS FOR CONCLUDING THAT THE PROCEDURE USED IS FAIR UNDER THE CIRCUMSTANCES: The Financial Services Commission believes that adopting an

emergency rule is the fairest method to protect the public to assure that insureds are timely notified of their PIP Benefits as required by Florida Law. Furthermore rulemaking proceedings are being pursued to adopt the Notification of PIP Rights form on a permanent basis and interested parties will have an opportunity to participate in the standard rulemaking process. An Office bulletin addressed to all regulated persons and insurers would reach them, but would not be legally binding. A permanent rule would not have the flexibility and immediacy to protect the public welfare.

In consideration of the emergency conditions currently existing, and given the Office's responsibility to protect the public interest and implement the Insurance Code, an emergency rule is necessary.

SUMMARY OF THE RULE: Emergency Rule 69OER12-01 requires insurers writing PIP insurance policies issued or renewed on or after January 1, 2013, in accordance with Chapter 2012-197,Laws of Florida, to utilize Form OIR-ER1-1149(New 1-1-2013) "Notification of Personal Injury Protection Benefits".

THE PERSON TO BE CONTACTED REGARDING THE EMERGENCY RULE IS: Michelle Brewer, Office of Insurance Regulation, Email Michelle.Brewer@floir.com.

THE FULL TEXT OF THE EMERGENCY RULE IS:

69OER12-01Emergency Adoption of Revised Notification of Personal Injury Protection Benefits Form.

(1) Chapter 2012-197, Laws of Florida(House Bill 119) revised the benefits available under the Florida No-Fault Law(Sections 627.730-627-7405 F.S.). Personal Injury Protection (PIP) Benefit policies issued or renewed in this state on or after January 1, 2013 in accordance with the provisions of Chapter 2012-197, Laws of Florida will be required to utilize Form OIR-ER1-1149(New 1-1-2013),"Notification of Personal Injury Protection Benefits" until such time as revisions to Form OIR-B1-1149(Rev. 8/30/06) is adopted by rule. Form OIR-ER1-1149(New 1-1-2013) is adopted and incorporated herein by reference and available at www.floir.com.

(2) Policies that do not provide the new benefits, shall continue to utilize Form OIR-B1-1149(Rev. 8/30/06).

(3) This Emergency Rule shall be effective on January 1, 2013

Specific Authority: 120.54(4), 624.308, 6277401 FS. Law Implemented: 626.7401, FS. History – New _____.

THIS RULE TAKES EFFECT UPON BEING FILED WITH THE DEPARTMENT OF STATE UNLESS A LATER TIME AND DATE IS SPECIFIED IN THE RULE.

NOTIFICATION OF PERSONAL INJURY PROTECTION BENEFITS
YOUR PERSONAL INJURY PROTECTION RIGHTS AND BENEFITS UNDER THE FLORIDA MOTOR VEHICLE NO-FAULT LAW

The Florida Motor Vehicle No-Fault Law does two things:

(1) It establishes a limited exemption from liability for injuries caused to others in an automobile accident; and

(2) It establishes personal injury protection (PIP) benefits to pay for certain losses resulting from an accident.

LEGAL RESPONSIBILITIES AND RIGHTS

Who is covered?

(1) If you are a resident of Florida and own a motor vehicle, you are required to purchase PIP. You are covered by PIP if you are the named insured. You, the insured, are covered by PIP while driving your vehicle or when a passenger in another's vehicle. You are also covered while outside a motor vehicle if struck and injured by a motor vehicle.

(2) Resident relatives who live with you, the insured, may be covered by your PIP benefits while they are driving your car, as passengers in your or another's car, and while pedestrians if struck and injured by a motor vehicle.

(3) Others who are injured while driving your insured motor vehicle or who are injured while a passenger in your insured motor vehicle or who are injured as a pedestrian when struck by your insured motor vehicle may be covered by your PIP.

(4) If you or your insured relatives living with you are injured while outside Florida, and are in your insured motor vehicle, you and your insured relatives are covered under PIP as long as the injury occurs within the United States, its territories or possessions, or in Canada

FRAUD ADVISORY NOTICE: Solicitation of a person injured in a motor vehicle crash for purposes of filing personal injury protection or tort claims could be a violation of Florida law or the rules regulating The Florida Bar and should be immediately reported to the Division of Insurance Fraud on-line at www.MyFloridaCFO~~fldfs~~.com/fraud or by calling 1-800-378-0445 from within Florida or 850-413-3261 from outside of Florida.

EXCEPTIONS

If your passengers or relatives living with you have a motor vehicle licensed in Florida or own a motor vehicle required to be licensed in Florida, they are not covered by your PIP coverage. They must purchase PIP for themselves to have coverage.

EXCLUSIONS

An insurer may exclude no-fault benefits:

(1) For injury sustained by any person operating the insured motor vehicle without your express or implied consent.

(2) To any injured person, if his/her conduct contributed to the injury under either of the following circumstances:

(a) causing injury to himself intentionally; or

(b) being injured while committing a felony.

(3) For injuries sustained by the named insured and relatives residing in the same household while occupying another motor vehicle owned by the named insured and not insured under the policy.

BENEFITS

The minimum limits for no-fault personal injury protection benefits are: ~~is~~

- $10,000 per person for loss ~~sustained as a~~ resulting from ~~of~~ bodily injury, sickness, or disease arising out of the ownership, maintenance, or use of a motor vehicle if a physician, dentist, physician assistant, or advanced registered nurse practitioner has determined that the injured person had an emergency medical condition. ~~($5,000 death) arising out of the ownership, maintenance, or use of a motor vehicle.~~
- $2,500 per person for loss resulting from bodily injury, sickness, or disease arising out of the ownership, maintenance, or use of a motor vehicle if a physician, dentist, physician assistant, or advanced registered nurse practitioner has determined that the injured person did not have an emergency medical condition, and
- $5,000 per individual for death benefits.

MEDICAL PAYMENTS

PIP medical benefits pays 80 percent of ~~medical benefits~~ for all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, ~~wheelchairs, crutches, slings, neck braces and splints.~~ and mMedically necessary ambulance, hospital and nursing services ~~are covered, and benefits also are paid for necessary remedial treatment and services recognized and permitted under the laws of the state for an injured person who relies solely upon spiritual means through prayer for healing because of religious beliefs.~~. . Medical benefits are only paid if the individual receives initial services and care within 14 days after the motor vehicle accident. Medical benefits do not include massage or acupuncture, regardless of the person, entity, or licensee providing massage or acupuncture and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits.

Note: Iif you have medical payments coverage through your auto insurance policy, then the medical payments coverage will be secondary to PIP coverage. The excess medical expenses, the 20 percent not covered by PIP, and the deductible may or may not be covered by the additional medical payments coverage depending on your particular policy.

BILLING REQUIREMENTS

Florida law ~~Statutes~~ provides that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The insured has a responsibility to furnish the provider with the correct name and address of the personal injury protection insurer. Failure to do so may result in delayed reimbursements to the provider.

At your initial treatment or service provided you will be required to sign a disclosure and acknowledgement form stating that the services were actually rendered, it is your right and duty

to confirm that those services were rendered, you were not solicited to seek services from the provider, the provider explained the services, and if you notify the insurer of a billing error you may be entitled to a share of the insurer's savings.

ADVISORY NOTICE: You may be entitled to a certain percentage of a reduction in the amount paid by the motor vehicle insurer if you notify that insurer of a billing error.

DISABILITY BENEFITS

PIP pays 60 percent of disability benefits for any loss of gross income and loss of earning capacity per individual from inability to work because of an injury sustained in an accident. Disability benefits also cover all expenses reasonably incurred for household services that, if not for injury, the injured person would have performed. Benefits must be paid not less than every two weeks.

DEATH BENEFITS

PIP pays ~~up to~~ $5,000 ~~of available benefits~~ per individual in death benefits. Death benefits are in addition to the medical and disability benefits provided under the insurance policy. The insurer may pay death ~~such~~ benefits to the executor or administrator of the deceased, to any of the deceased's relatives, including those related by marriage, or to any person appearing to the insurer to be equitably entitled to the payment.

OPTIONAL DEDUCTIBLES AND LIMITATIONS

1. Persons subject to deductibles may be able to recover the amount of the deductible from a tortfeasor otherwise exempt from liability under Section 627.737, F.S.
2. Deductibles must be applied to the entire amount of any expenses and losses described under required personal injury protection benefits. After the deductible is met, each insured is eligible to receive up to $10,000 in benefits. Thus, for instance, an insured with a $1,000 deductible would have to incur $13,500 in medical expenses (assuming no

disability or death benefits) in order to receive the entire $10,000 in benefits [($13,500-$1,000) x 80%].

3. Deductibles of $250, $500 and $1,000 must be offered but may not be required.
4. You may have elected that the benefits from loss of gross income and loss of earning capacity (disability benefits) be excluded from your PIP benefits.

COORDINATION OF BENEFITS

PIP benefits are primary over other insurance coverage, except that workers' compensation benefits received will be credited against PIP benefits. This means that your PIP insurer is ultimately responsible for payment of your claim. How this works in a specific situation depends upon the contract language in the other insurance policy.

PAYMENT OF BENEFITS

PIP benefits will be payable as loss accrues and reasonable proof of the loss and the expenses are provided. Before PIP benefits are paid, an insurer may require written notice be given as soon as possible after an accident involving a motor vehicle.

PIP benefits are overdue if not paid within 30 days after the insurer is provided written notice of a covered loss and of the total amount of the claim. If a partial claim is made, that partial amount must be paid within 30 days after the insurer receives written notice.

Any part, or all of the remainder, of the claim that is later supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. However, any payment shall not be deemed overdue when the insurer has reasonable proof showing that the insurer is not responsible for the payment even though written notice has been furnished to the insurer.

For the purpose of calculating overdue payments, payment is considered as being made on the date it was postmarked or, if not posted, on the date of delivery. All overdue payments will pay simple interest at the rate established in your policy, or pursuant to s. 55.03, F.S., whichever is greater.

WHAT DO I DO TO RESOLVE DISPUTES REGARDING PIP BENEFITS?

(1) In the event you are having a dispute with the insurer for PIP benefits, you may demand mediation of the claim before resorting to the courts by filing a request with the Department of Financial Services "Department" on Form DFS-H2-510 provided by the Department.

(2) Mediation is an informal process whereby a neutral mediator selected by the Department ~~Office~~ will work together with you and the insurer to resolve the dispute.

You may reach the Department at a local service office or call 1-800-342-2762.

PLEASE NOTE: This description of your rights contains general statements and should not be construed to enhance, alter, or amend your rights under your policy and Florida law.

FRAUD ADVISORY NOTICE: The Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of certain Florida Statutes. You may report such fraud on-line at www.MyFloridaCFO~~fldfs~~.com/fraud or by calling 1-800-378-0445 from within Florida or 850-413-3261 from outside of Florida.