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

November 9, 2010

MEMBERS
Governor Charlie Crist
Attorney General Bill McCollum
Chief Financial Officer Alex Sink
Commissioner Charles Bronson

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 August 10, 2010.

   (ATTACHMENT 1) **FOR APPROVAL**

2. Request for Approval for Publication of Amendments to Proposed Rule 69O-170.0155;Uniform Mitigation Verification Inspection Form OIR-B1-1802

   The rule is being amended to update Form OIR-B1-1802 "Uniform Mitigation Verification Inspection Form" in order to reflect 2010 statutory changes and other issues related to the form which is incorporated by reference in rule 69O-170.0155 F.A.C.

   (ATTACHMENT 2) **APPROVAL FOR PUBLICATION**

3. Update on Second Quarter Surplus and Underwriting Results for Florida's Property Insurance Marketplace

   (ATTACHMENT 3) **FOR INFORMATION**

Minutes of the Financial Services Commission
August 10, 2010

Members	Presented by: Kevin McCarty
Charlie Crist, Governor	Cabinet Meeting Room, Lower Level, The Capitol
Alex Sink, Chief Financial Officer	Tallahassee, Florida 32399
Bill McCollum, Attorney General	
Charles Bronson, Agriculture Commissioner	

Item 1: Minutes of the Financial Services Commission for April 13, 2010, May 11, 2010 and June 8, 2010

Upon motion by Agriculture Commissioner Charles Bronson and seconded by Attorney General Bill McCollum, the item was approved.

Item 2: Request for Approval for Adoption of Amendments to Proposed Rule 69O-137.002, Model Audit Rule

Upon motion by Attorney General Bill McCollum and seconded by Agriculture Commissioner Charles Bronson, the item was approved.

Item 3: Request for Approval for Adoption of Amendments to Proposed Rule 69O-167.024

Upon motion by Chief Financial Officer Alex Sink and seconded by Attorney General Bill McCollum, the item was approved.

Item 4: Request for Approval for Publication of Amendments to Proposed Rule 69O-162.203, Adoption of 2001 Commissioners Standard Ordinary (CSO) Ultimate Mortality Tables for Determining Reserve Liabilities for Credit Life Insurance

Upon motion by Chief Financial Officer Alex Sink and seconded by Agriculture Commissioner Charles Bronson, the item was approved.

Item 5: Request for Approval for Publication of Amendments to Proposed Rule 69O-164.020, Valuation of Life Insurance Policies

Upon motion by Attorney General Bill McCollum and seconded by Chief Financial Officer Alex Sink, the item was approved.

Item 6: Request for Approval for Publication of Amendments to Proposed Rule 69O-138.047, Description of Actuarial Memorandum

Upon motion by Chief Financial Officer Alex Sink and seconded by Agriculture Commissioner Charles Bronson, the item was approved.

M E M O R A N D U M

DATE: October 28, 2010

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

THROUGH: Steven H. Parton, General Counsel

FROM: Dennis Threadgill
Bob Prentiss

SUBJECT: Cabinet Agenda for October 26, 2010
Request for Approval to Publish Amendments to
Rule 69O-170.0155
Assmt. # 44317

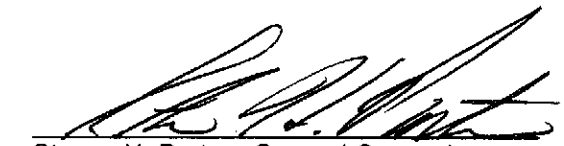
The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before October 20, 2010 and to the Financial Services Commission on November 9, 2010, with a request to approve for publication the proposed rules.

To update Form OIR-B1-1802 "Uniform Mitigation Verification Inspection Form" to reflect 2010 statutory changes and other issues related to the form which is incorporated by reference in rule 69O-170.0155 F.A.C.

Sections 624.308(1), 627.711, 627.736, 215.5586, 624.307(1), 627.062, 627.0629, 627.0645, 626.711, 627.736, F.S., provide rulemaking authority and laws implemented for this rule.

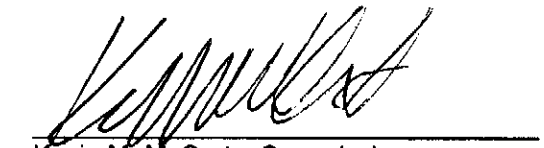
Stephen Fredrickson is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:



Steven H. Parton, 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)(l) OIR-B1-1802, "Uniform Mitigation Verification Inspection Form," (Rev. 01/11 ~~2/10~~).

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).

Uniform Mitigation Verification Inspection Form

Maintain a copy of this form with the insurance policy

Inspection Date:		
Owner Information		
Owner Name:		Contact Person:
Address:		Home Phone:
City:	Zip:	Work Phone:
County:		Cell Phone:
Insurance Company:		Policy #:
Year of Home:	# of Stories:	Email:

1. **Building Code:** What building code was used to design and build the structure?

   ☐ A. 1994 South Florida Building Code (building permit application date of 9/1/1994 or later in Miami-Dade and Broward Counties (also known as the High Velocity Hurricane Zone (HVHZ)).

   ☐ B. Building code prior to the 1994 South Florida Building Code (building permit application date of 8/31/1994 or earlier in Miami-Dade and Broward Counties (HVHZ).

   ☐ C. 2001 Florida Building Code (building permit application date of 3/1/2002 or later outside the HVHZ).

   ☐ D. Building code prior to the 2001 Florida Building Code (building permit application date of 2/28/2002 or earlier outside the HVHZ).

   ☐ E. Unknown or undetermined.

2. **Predominant Roof Covering:**
   Permit Application Date: _____ or Date of Installation: _____

   ☐ A. At a minimum meets the 2001 Florida Building Code or the 1994 South Florida Building Code and has a Miami-Dade NOA or FBC 2001 Product Approval listing demonstrating compliance with ASTM D 3161 (enhanced for 110MPH) OR ASTM D 7158 (F, G or H), OR FBC TAS 100-95 and TAS 107-95, OR FMRC 4470 and/or 4471 (for metal roofs).

   ☐ B. Does not meet the above minimum requirements.

   ☐ C. Unknown or undetermined.

NOTE: At least one photo documenting the existence of each visible and accessible construction or mitigation attribute marked in Sections 3 through 9 must accompany this form.

3. **Roof Deck Attachment:** What is the **weakest** form of roof deck attachment?

   ☐ A. Plywood/Oriented strand board (OSB) roof sheathing attached to the roof truss/rafter (spaced a maximum of 24" o.c.) by staples or 6d nails spaced at 6" along the edge and 12" in the field. **-OR-** Batten decking supporting wood shakes or wood shingles.**-OR-** Any system of screws, nails, adhesives, other deck fastening system or truss/rafter spacing that has an equivalent mean uplift resistance of 55 psf.

   ☐ B. Plywood/OSB roof sheathing with a minimum thickness of 7/16" attached to the roof truss/rafter (spaced a maximum of 24" o.c.) by 8d common nails spaced 6" along the edge and 12" in the field.**-OR-** Any system of screws, nails, adhesives, other deck fastening system or truss/rafter spacing that has an equivalent mean uplift resistance of 103 psf.

   ☐ C. Plywood/OSB roof sheathing with a minimum thickness of 7/16" attached to the roof truss/rafter (spaced a maximum of 24" o.c.) by 8d common nails spaced 6" along the edge and 6" in the field. **-OR-** Dimensional lumber/Tongue & Groove decking with a minimum of 2 nails per board. **-OR-** Any system of screws, nails, adhesives, other deck fastening system or truss/rafter spacing that has an equivalent mean uplift resistance of 182 psf.

   ☐ D. Reinforced Concrete Roof Deck.

   ☐ E. Other: _____

   ☐ F. Unknown or unidentified.

   ☐ G. No attic access.

Inspectors Initials _____ Property Address_____

***This verification form is valid up to five (5) years provided no material changes have been made to the structure.**

4. **Roof to Wall Attachment:** What is the **weakest** roof to wall connection?
   - ☐ A. Toe Nails — Rafter/truss anchored to top plate of wall using nails driven at an angle through the rafter/truss and attached to the top plate of the wall.
   - ☐ B. Clips — Metal attachments on every rafter/truss that are nailed to one side (or both sides in the case of a diamond type clip) of the rafter/truss and attached to the top plate of the wall frame or embedded in the bond beam.
   - ☐ C. Single Wraps — Metal Straps must be secured to every rafter/truss with a minimum of 3 nails, wrapping over and securing to the opposite side of the rafter/truss with a minimum of 1 nail. The Strap must be attached to the top plate of the wall frame or embedded in the bond beam in at least one place.
   - ☐ D. Double Wraps — Both Metal Straps must be secured to every rafter/truss with a minimum of 3 nails, wrapping over and securing to the opposite side of the rafter/truss with a minimum of 1 nail. Each Strap must be attached to the top plate of the wall frame or embedded in the bond beam in at least one place.
   - ☐ E. Structural — Anchor bolts structurally connected or reinforced concrete roof.
   - ☐ F. Other: _____
   - ☐ G. Unknown or Unidentified
   - ☐ H. No attic access

5. **Roof Geometry:** What is the roof shape(s)? (Porches or carports that are attached only to the fascia or wall of the host structure and not structurally connected to the main roof system are not considered in the roof geometry determination.)
   - ☐ A. Hip Roof — Hip roof with no other roof shapes greater than 10% of the total building perimeter.
   - ☐ B. Non-Hip Roof — Any other roof shape or combination of roof shapes including hip, gable, gambrel, mansard and other roof shapes not including flat roofs.
   - ☐ C. Flat Roof — Flat roof shape greater than 100 square feet or 10% of the entire roof, whichever is greater.

6. **Gable End Bracing:** For roof structures that contain gables, please check the **weakest** that apply:
   - ☐ A. Gable End(s) are braced at a minimum in accordance with the 2001 Florida Building Code.
   - ☐ B. Does not meet the above minimum requirements.
   - ☐ C. Not applicable, unknown or unidentified.

7. **Wall Construction Type:** Check all wall construction types for exterior walls of the structure and percentages for each:
   - ☐ A. Wood Frame _____%
   - ☐ B. Un-Reinforced Masonry _____%
   - ☐ C. Reinforced Masonry _____%
   - ☐ D. Poured Concrete _____%
   - ☐ E. Other: _____ _____%

8. **Secondary Water Resistance (SWR):** (standard underlayments or hot mopped felts are not SWR)
   - ☐ A. SWR — Self adhering polymer modified bitumen roofing underlayment applied directly to the sheathing or foam adhesive SWR barrier (not foamed on insulation) applied as a secondary means to protect the dwelling from water intrusion.
   - ☐ B. No SWR
   - ☐ C. Unknown or undetermined.

Inspectors Initials _____ **Property Address** _____

***This verification form is valid up to five (5) years provided no material changes have been made to the structure.**

9. **Opening Protection**: What is the **weakest** form of wind borne debris protection installed on the structure? (Exterior openings include, but are not limited to: windows, doors, garage doors, skylights, etc. Product approval may be required for opening protection devices without proper rating identification.)

☐ A. **All Exterior Openings (Glazed and Unglazed)** All exterior openings are fully protected at a minimum with impact resistant coverings, impact resistant doors and/or impact resistant window units that are listed as wind borne debris protection devices in the product approval system of the State of Florida or Miami-Dade County and meet the requirements of one of the following for "Cyclic Pressure and Large Missile Impact". For the HVHZ, systems must have either a Miami-Dade NOA or FBC Approval marked *"For Use in the HVHZ"*.

- ☐ Miami-Dade County Notice of Acceptance (NOA) 201, 202 **and** 203. (Large Missile - 9 lb.)
- ☐ Florida Building Code Testing Application Standard (TAS) 201, 202 **and** 203. (Large Missile – 9 lb.)
- ☐ American Society for Testing and Materials (ASTM) E 1886 **and** ASTM E 1996. (Large Missile – 9 lb.)
- ☐ Southern Standards Technical Document (SSTD) 12. (Large Missile – 9 lb.)
- ☐ For Skylights Only: ASTM E 1886/E 1996. (Large Missile - 4.5 lb.)
- ☐ For Garage Doors Only: ANSI/DASMA 115. (Large Missile – 9 lb.)

☐ B. **All exterior openings** are fully protected at a minimum with impact resistant coverings, impact resistant doors and/or impact resistant window units that are listed as windborne debris protection devices in the product approval system of the State of Florida or Miami-Dade County and meet the requirements of one of the following for "Cyclic Pressure and Large Missile Impact":

- ☐ ASTM E 1886 and ASTM E 1996. (Large Missile – 4.5 lb.)
- ☐ SSTD 12. (Large Missile – 4 lb. to 8 lb.)
- ☐ For Skylights Only: ASTM E 1886/E 1996. (Large Missile - 2 to 4.5 lb.)

☐ C. **All exterior openings** are fully protected at a minimum with impact resistant coverings, impact resistant doors and/or impact resistant window units that are listed as windborne debris protection devices in the product approval system of the State of Florida or Miami-Dade County and meet the requirements of one of the following for "Cyclic Pressure and Small Missile Impact":

- ☐ Miami-Dade County NOA 201, 202 **and** 203. (Small Missile – 2grams)
- ☐ Florida Building Code TAS 201, 202 **and** 203. (Small Missile – 2 grams)
- ☐ ASTM E 1886 **and** ASTM E 1996. (Small Missile – 2 grams)
- ☐ SSTD 12. (Small Missile – 2 grams)

☐ D. **All exterior openings** are fully protected with windborne debris protection devices that cannot be identified as Miami-Dade or Florida Building Code (FBC) product approved. This does not include plywood/OSB or plywood alternatives (see Answer "H").

All Glazed Exterior Openings

☐ E. **All glazed exterior openings** are fully protected at a minimum with impact resistant coverings and/or impact resistant window units that meet the requirements of one of the standards listed in Answer "A" of this question. (Large Missile – 9 lb.)

☐ F. **All glazed exterior openings** are fully protected at a minimum with impact resistant coverings and/or impact resistant window units that meet the requirements of one of the standards listed in Answer "B" of this question. (Large Missile – 2 lb. - 8 lb.)

☐ G. **All glazed exterior openings** are fully protected at a minimum with impact resistant coverings and/or impact resistant window units that meet the requirements of one of the standards listed in Answer "C" of this question. (Small Missile – 2 grams)

☐ H. **All glazed exterior openings** are covered with plywood/OSB meeting the requirements of Section 1609 and Table 1609.1.4 of the 2004 FBC (with 2006 supplements).

☐ I. **All glazed exterior openings** are fully protected with wind-borne debris protection devices that cannot be identified as Miami-Dade or FBC product approved. This does not include plywood/OSB or other plywood alternatives that do not meet Answer H (see Answer "K").

None or Some Glazed Openings

☐ J. At least one glazed exterior opening does not have wind-borne debris protection.

☐ K. No glazed exterior openings have wind-borne debris protection. This includes plywood/OSB or plywood alternative systems that do not meet Answer "H".

☐ L. Unknown or undetermined.

Inspectors Initials _____ **Property Address**_____

***This verification form is valid up to five (5) years provided no material changes have been made to the structure.**

MITIGATION INSPECTIONS MUST BE CERTIFIED BY A QUALIFIED INSPECTOR. **Section 627.711(2), Florida Statutes, provides a listing of individuals who may sign this form.**		
Qualified Inspector Name:	License Type:	License or Certificate #:
Inspection Company:		Phone:

Qualified Inspector – I hold an active license as a: (check one)

- ☐ Home inspector licensed under Section 468.8314, Florida Statutes who has completed at least 3 hours of hurricane mitigation training and completion of a proficiency exam.
- ☐ Building code inspector certified under Section 468.607, Florida Statutes.
- ☐ General, building or residential contractor licensed under Section 489.111, Florida Statutes.
- ☐ Professional engineer licensed under Section 471.015, Florida Statutes.
- ☐ Professional architect licensed under Section 481.213, Florida Statutes.
- ☐ Any other individual or entity recognized by the insurer as possessing the necessary qualifications to properly complete a uniform mitigation verification form pursuant to Section 627.711(2), Florida Statutes.

Individuals other than licensed contractors licensed under Section 489.111, Florida Statutes, or professional engineer licensed under Section 471.015, Florida Statues, must inspect the structures personally and not through employees or other persons. Licensees under s.471.015 or s.489.111 may authorize a direct employee who possesses the requisite skill, knowledge, and experience to conduct a mitigation verification inspection.

I, _____ am a qualified inspector and I personally performed the inspection or (*licensed contractors and professional engineers only*) I had my employee (_____) perform the inspection and I agree to be responsible for his/her work.
(print name) (print name of inspector)

Qualified Inspector Signature: _____ Date: _____

An individual or entity who knowingly or through gross negligence provides a false or fraudulent mitigation verification form is subject to investigation by the Florida Division of Insurance Fraud and may be subject to administrative action by the appropriate licensing agency or to criminal prosecution. (Section 627.711(4)-(7), Florida Statutes) The Qualified Inspector who certifies this form shall be directly liable for the acts of employees as if the authorized mitigation inspector personally performed the inspection.

Homeowner to complete: I certify that the named Qualified Inspector or his or her employee did perform an inspection of the residence identified on this form and that proof of identification was provided to me or my Authorized Representative.

Signature: _____ Date: _____

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. (Section 627.711(7), Florida Statutes)

The definitions on this form are for inspection purposes only and cannot be used to certify any product or construction feature as offering protection from hurricanes.

Inspectors Initials _____ Property Address _____

***This verification form is valid up to five (5) years provided no material changes have been made to the structure.**

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.

627.7011 Homeowners' policies; offer of replacement cost coverage and law and ordinance coverage.--

(1) Prior to issuing a homeowner's insurance policy on or after October 1, 2005, or prior to the first renewal of a homeowner's insurance policy on or after October 1, 2005, the insurer must offer each of the following:

(a) A policy or endorsement providing that any loss which is repaired or replaced will be adjusted on the basis of replacement costs not exceeding policy limits as to the dwelling, rather than actual cash value, but not including costs necessary to meet applicable laws and ordinances regulating the construction, use, or repair of any property or requiring the tearing down of any property, including the costs of removing debris.

(b) A policy or endorsement providing that, subject to other policy provisions, any loss which is repaired or replaced at any location will be adjusted on the basis of replacement costs not exceeding policy limits as to the dwelling, rather than actual cash value, and also including costs necessary to meet applicable laws and ordinances regulating the construction, use, or repair of any property or requiring the tearing down of any property, including the costs of removing debris; however, such additional costs necessary to meet applicable laws and ordinances may be limited to either 25 percent or 50 percent of the dwelling limit, as selected by the policyholder, and such coverage shall apply only to repairs of the damaged portion of the structure unless the total damage to the structure exceeds 50 percent of the replacement cost of the structure.

An insurer is not required to make the offers required by this subsection with respect to the issuance or renewal of a homeowner's policy that contains the provisions specified in paragraph (b) for law and ordinance coverage limited to 25 percent of the dwelling limit, except that the insurer must offer the law and ordinance coverage limited to 50 percent of the dwelling limit. This subsection does not prohibit the offer of a guaranteed replacement cost policy.

(2) Unless the insurer obtains the policyholder's written refusal of the policies or endorsements specified in subsection (1), any policy covering the dwelling is deemed to include the law and ordinance coverage limited to 25 percent of the dwelling limit. The rejection or selection of alternative coverage shall be made on a form approved by the office. The form shall fully advise the applicant of the nature of the coverage being rejected. If this form is signed by a named insured, it will be conclusively presumed that there was an informed, knowing rejection of the coverage or election of the alternative coverage on behalf of all insureds. Unless the policyholder requests in writing the coverage specified in this section, it need not be provided in or supplemental to any other policy that renews, insures, extends, changes, supersedes, or replaces an existing policy when the policyholder has rejected the coverage specified in this section or has selected alternative coverage. The insurer must provide such policyholder with notice of the availability of such coverage in a form approved by the office at least once every 3 years. The failure to provide such notice constitutes a violation of this code, but does not affect the coverage provided under the policy.

(3) In the event of a loss for which a dwelling or personal property is insured on the basis of replacement costs, the insurer shall pay the replacement cost without reservation or holdback of any depreciation in value, whether or not the insured replaces or repairs the dwelling or property.

(4) Any homeowner's insurance policy issued or renewed on or after October 1, 2005, must include in bold type no smaller than 18 points the following statement:

"LAW AND ORDINANCE COVERAGE IS AN IMPORTANT COVERAGE THAT YOU MAY WISH TO PURCHASE. YOU MAY ALSO NEED TO CONSIDER THE PURCHASE OF FLOOD INSURANCE FROM THE NATIONAL FLOOD INSURANCE PROGRAM. WITHOUT THIS COVERAGE, YOU MAY HAVE UNCOVERED LOSSES. PLEASE DISCUSS THESE COVERAGES WITH YOUR INSURANCE AGENT."

The intent of this subsection is to encourage policyholders to purchase sufficient coverage to protect them in case events excluded from the standard homeowners policy, such as law and ordinance enforcement and flood, combine with covered events to produce damage or loss to the insured property. The intent is also to encourage policyholders to discuss these issues with their insurance agent.

(5) Nothing in this section shall be construed to apply to policies not considered to be "homeowners' policies," as that term is commonly understood in the insurance industry. This section specifically does not apply to mobile home policies. Nothing in this section shall be construed as limiting the ability of any insurer to reject or nonrenew any insured or applicant on the grounds that the structure does not meet underwriting criteria applicable to replacement cost or law and ordinance policies or for other lawful reasons.

(6) This section does not prohibit an insurer from limiting its liability under a policy or endorsement providing that loss will be adjusted on the basis of replacement costs to the lesser of:

(a) The limit of liability shown on the policy declarations page;

(b) The reasonable and necessary cost to repair the damaged, destroyed, or stolen covered property; or

(c) The reasonable and necessary cost to replace the damaged, destroyed, or stolen covered property.

(7) This section does not prohibit an insurer from exercising its right to repair damaged property in compliance with its policy and s. 627.702(7).

627.736 Required personal injury protection benefits; exclusions; priority; claims.--

(1) REQUIRED BENEFITS.--Every insurance policy complying with the security requirements of s. 627.733 shall provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to the provisions of subsection (2) and paragraph (4)(e), to a limit of $10,000 for loss sustained by any such person as a result of 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. However, the medical benefits shall provide reimbursement only for such 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 by any of the following persons or entities:

1. A hospital or ambulatory surgical center licensed under chapter 395.

2. A person or entity licensed under ss. 401.2101-401.45 that provides emergency transportation and treatment.

3. 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 that practitioner or those practitioners.

4. An entity wholly owned, directly or indirectly, by a hospital or hospitals.

5. A health care clinic licensed under ss. 400.990-400.995 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

b. A health care clinic that:

(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.

The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in subparagraph 3., subparagraph 4., or subparagraph 5. 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 shall be paid not less than every 2 weeks.

(c) *Death benefits.*--Death benefits equal to the lesser of $5,000 or the remainder of unused personal injury protection benefits per individual. The insurer may pay such benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and no such insurer shall 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 required 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. Any insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice shall be deemed to have violated part IX of chapter 626, and such violation shall constitute an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance; and any such insurer committing such violation shall be subject to the penalties afforded in such part, as well as those which may be afforded 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) BENEFITS; WHEN DUE.--Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be 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. When 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, benefits under ss. 627.730-627.7405 shall be subject to the provisions of 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 shall be 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. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such 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 such written notice is furnished to the insurer. When 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, provided that this shall not limit the introduction of evidence at trial; and the insurer shall include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence. However, notwithstanding the fact that written notice has been furnished to the insurer, any payment shall not be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment. For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which 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. 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 by the insurer may be made at any time, including after payment of the claim or after the 30-day time 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(9), 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 a claim from a physician or dentist who provided emergency services and care or who provided hospital inpatient care may then be used by the insurer to pay other claims. The time periods specified in paragraph (b) for required payment of personal injury protection benefits shall be tolled for the period of time that an

insurer is required by this paragraph to hold payment of a claim that is not from a physician or dentist who provided emergency services and care or who provided hospital inpatient care 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 shall bear simple interest at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, for the year in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of covered loss. Interest shall be 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., provided the relative at the time of the accident is domiciled in the owner's household and is not himself or herself 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, provided the injured person is not himself or herself:

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 or owners of such a motor vehicle.

(f) If two or more insurers are liable to pay personal injury protection benefits for the same injury to any one person, the maximum payable shall be as specified in subsection (1), and any insurer paying the benefits shall be 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 shall not be due or payable to or on the behalf of an insured person if that person has committed, by a material act or omission, any 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 if it is established in a court of competent jurisdiction. Any insurance fraud shall void 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 prior to the discovery of the insured person's insurance fraud shall be recoverable by the insurer from the person who committed insurance fraud in their entirety. The

prevailing party is entitled to its costs and attorney's fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.--

(a)1. Any 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. In no event, however, may such a charge be in excess of the amount the person or institution customarily charges for like services or supplies. With respect to a determination of 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, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

2. 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(9) 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 the participating physicians schedule of Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, 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.

3. For purposes of subparagraph 2., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect at the time the services, supplies, or care was rendered and for the area in which such services were rendered, except that it may not be less than

the allowable amount under the participating physicians schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

4. Subparagraph 2. 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 2. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider would be 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.

5. If an insurer limits payment as authorized by subparagraph 2., 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.

(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 to 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, provided that before doing so, the insurer must contact the health care provider and discuss the reasons for the insurer's change and the health care provider's reason for the coding, or make 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 initial list shall be adopted by January 1, 2004, and 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 of invalid diagnostic tests shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and shall 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 any invalid diagnostic test as determined by the Department of Health.

(c)1. With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services 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 shall 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.

2. If, however, 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.

3. 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, the provider is not required to furnish the statement of charges within the time periods established by this paragraph; and the insurer shall not be 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 Health Care Finance Administration.

4. Each notice of insured's rights under s. 627.7401 must include the following statement in type no smaller than 12 points:

BILLING REQUIREMENTS.--Florida Statutes provide 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 any 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 shall, 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 Centers for Medicare and Medicaid Services (CMS) 1500 form instructions and the American Medical Association Current Procedural Terminology (CPT) Editorial Panel and Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals shall 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 (OIG), Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. No statement of medical services may 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 shall not be 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 unless the statements or bills 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. This disclosure and acknowledgment form is not required for services billed by a provider for emergency services as defined in s. 395.002, 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 that shall be used to fulfill the requirements of this paragraph, effective 90 days after such form is adopted and becomes final. The commission shall adopt a proposed rule by October 1, 2003. Until the rule is final, the provider may use a form of its own which otherwise complies with the requirements of this paragraph.

8. As used in this paragraph, "countersigned" 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, that is consistent with the services being rendered to the patient as claimed. The requirements of this subparagraph for maintaining 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 shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such 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, then 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.

(6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.--

(a) Every employer shall, 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, furnish forthwith, 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 to do so by the insurer against whom the claim has been made, furnish forthwith 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 forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment; provided that this shall not limit the introduction of evidence at trial. Such sworn statement shall 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." No cause of action for violation of the physician-patient privilege or invasion of the right of privacy shall be permitted against any physician, hospital, clinic, or other medical institution complying with the provisions of 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 which is the subject of the insurer's inquiry shall become 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. For purposes of this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. Any 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 any 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 it shall specify the time, place, manner, conditions, and scope of the discovery. Such court may, in order to protect against annoyance, embarrassment, or oppression, as justice requires, 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 the provisions of this section, and shall pay a reasonable charge, if required by the insurer.

(e) Notice to an insurer of the existence of a claim shall not be unreasonably withheld by an insured.

(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, then 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 an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S 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 s. 627.428 shall apply, except as provided in subsections (10) and (15).

(9) An insurer may negotiate and enter into contracts with licensed health care providers for the benefits described in this section, referred to in this section as "preferred providers," which shall include health care providers licensed under chapters 458, 459, 460, 461, and 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchase of 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 policyholder 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 principal office of the insurer within the state.

(10) DEMAND LETTER.--

(a) As a condition precedent to filing any action for benefits under this section, the insurer must be provided with written notice of an intent to initiate litigation. 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 required shall state that it is a "demand letter under s. 627.736(10)" and shall 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 so 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 designation of the name and address of the person to whom notices pursuant to this subsection shall 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 shall be deemed the authorized representative to accept notice pursuant to this subsection in the event 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 shall not be 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's 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 a period of 30 business days by the mailing of the notice required by this subsection.

(f) Any insurer making a general business practice of not paying valid claims until receipt of the notice required by this subsection is engaging in an unfair trade practice under the insurance code.

(11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE PRACTICE.--

(a) If an insurer fails to pay valid claims for personal injury protection with such frequency so as to indicate a general business practice, the 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 with respect thereto.

(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.--If all parties mutually and expressly agree, 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.

TAXATION AND FINANCE

Chapter 215
FINANCIAL MATTERS: GENERAL PROVISIONS

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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.

4. A hurricane resistance rating scale specifying the home's current as well as projected wind resistance capabilities. As soon as practical, the rating scale must be the uniform home grading scale adopted by the Financial Services Commission pursuant to s. 215.55865.

(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 level 2 background checks pursuant to s. 435.04. 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(10), 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(10), 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(10) 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 7 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 2 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 shall 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 to allow the insurer a reasonable rate of return on such 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, shall be filed with the office under one of the following procedures except as provided in subparagraph 3.:

1. If the filing is made at least 90 days before the proposed effective date and the filing is not implemented during the office's review of the filing and any proceeding and judicial review, then such filing shall be 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 shall 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 the provisions of subparagraph 1., such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders portions of rates found to be excessive, as provided in paragraph (h).

3. For all property insurance filings made or submitted after January 25, 2007, but before December 31, 2010, 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 to be property coverages.

(b) Upon receiving a rate filing, the office shall review the rate 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 shall calculate investment income attributable to such classes of insurance written in this state and the manner in which such investment income shall be used to calculate insurance rates. Such manner shall 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 shall 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 which impact upon the frequency or severity of claims or upon expenses.

(c) In the case of fire insurance rates, consideration shall 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 given consideration 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 shall maintain the premium in a catastrophe reserve. Any removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes shall be subject to approval of the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes shall be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), a rate may be found by the office 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 that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.

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, when 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 a period of 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the office all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to the procedures of 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 shall not alter the rate except to conform with the office's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of the implementation of the rate. The office may, subject to chapter 120, disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(h) In the event the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule which responds to the findings of the office be filed by the insurer. The office shall further order, for

any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to such policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding shall be applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(i) Except as otherwise specifically provided in this chapter, the office shall not 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.

(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. An insurer may make a separate filing limited solely to an adjustment of its rates for reinsurance or financing costs incurred in the purchase of reinsurance or financing products to replace or finance the payment of the amount covered by the Temporary Increase in Coverage Limits (TICL) portion of the Florida Hurricane Catastrophe Fund including replacement reinsurance for the TICL reductions made pursuant to s. 215.555(17)(e); the actual cost paid due to the application of the TICL premium factor pursuant to s. 215.555(17)(f); 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 the 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 10 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 demonstrates that the costs meet the criteria of this section and are not loaded for expenses or profit for the insurer making the filing.

c. Includes no other changes to its rates in the filing.

d. Has not implemented a rate increase within the 6 months immediately preceding the filing.

e. Does not file for a rate increase under any other paragraph within 6 months after making a filing under this paragraph.

f. That purchases reinsurance or financing products from an affiliated company in compliance with this paragraph does so 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.

2. An insurer may only make one filing in any 12-month period under this paragraph.

3. 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 [1]shall not apply to workers' compensation and employer's liability insurance and to 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 which 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 a period of 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.

(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. In order to enhance the ability of consumers to compare premiums and to increase the accuracy and usefulness of rate-comparison information provided by the office to the public, the office shall develop a proposed standard rating territory plan to be used by all authorized property and casualty insurers for residential property insurance. In adopting the proposed plan, the office may consider geographical characteristics relevant to risk, county lines, major roadways, existing rating territories used by a significant segment of the market, and other relevant factors. Such plan shall be submitted to the President of the Senate and the Speaker of the House of Representatives by January 15, 2006. The plan may not be implemented unless authorized by further act of the Legislature.

(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 Florida Hurricane Catastrophe Fund, together with reasonable costs of other reinsurance, but except as otherwise provided in this section, may not recoup reinsurance costs that duplicate coverage provided by the Florida Hurricane Catastrophe 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 shall 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 shall 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 be allowed 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)(a) The provisions of this subsection apply only with respect to rates for medical malpractice insurance and shall control to the extent of any conflict with other provisions of this section.

(b) 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 shall not be 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 in these judgments and settlements may not be included in the insurer's rate base and may not be utilized to justify a rate or rate change.

(c) 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, either 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.

(d) 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.

(e) The insurer must apply a discount or surcharge based on the health care provider's loss experience or shall 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 must provide a copy of such schedule or description, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.

(f) 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)1. No later than 60 days after the effective date of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature, the office shall calculate a presumed factor that reflects the impact that the changes contained in such legislation will have on rates for medical malpractice insurance and shall issue a notice informing all insurers writing medical malpractice coverage of such presumed factor. In determining the presumed factor, the office shall use generally accepted actuarial techniques and standards provided in this section in determining the expected impact on losses, expenses, and investment income of the insurer. To the extent that the operation of a provision of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature is stayed pending a constitutional challenge, the impact of that provision shall not be included in the calculation of a presumed factor under this subparagraph.

2. No later than 60 days after the office issues its notice of the presumed rate change factor under subparagraph 1., each insurer writing medical malpractice coverage in this state shall submit to the office a rate filing for medical malpractice insurance, which will take effect no later than January 1, 2004, and apply retroactively to policies issued or renewed on or after the effective date of medical

malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature. Except as authorized under paragraph (b), the filing shall reflect an overall rate reduction at least as great as the presumed factor determined under subparagraph 1. With respect to policies issued on or after the effective date of such legislation and prior to the effective date of the rate filing required by this subsection, the office shall order the insurer to make a refund of the amount that was charged in excess of the rate that is approved.

(b) Any insurer or rating organization that contends that the rate provided for in paragraph (a) is excessive, inadequate, or unfairly discriminatory shall separately state in its filing the rate it contends is appropriate and shall state with specificity the factors or data that it contends should be considered in order to produce such appropriate rate. The insurer or rating organization shall be permitted to use all of the generally accepted actuarial techniques provided in this section in making any filing pursuant to this subsection. The office shall review each such exception and approve or disapprove it prior to use. It shall be the insurer's burden to actuarially justify any deviations from the rates required to be filed under paragraph (a). The insurer making a filing under this paragraph shall include in the filing the expected impact of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature on losses, expenses, and rates.

(c) If any provision of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature is held invalid by a court of competent jurisdiction, the office shall permit an adjustment of all medical malpractice rates filed under this section to reflect the impact of such holding on such rates so as to ensure that the rates are not excessive, inadequate, or unfairly discriminatory.

(d) Rates approved on or before July 1, 2003, for medical malpractice insurance shall remain in effect until the effective date of a new rate filing approved under this subsection.

(e) The calculation and notice by the office of the presumed factor pursuant to paragraph (a) is not an order or rule that is subject to chapter 120. If the office enters into a contract with an independent consultant to assist the office in calculating the presumed factor, such contract shall not be subject to the competitive solicitation requirements of s. 287.057.

(9)(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 in order 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 knowingly making 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 commission may adopt rules and forms pursuant to ss. 120.536(1) and 120.54 to administer this subsection.

(10) 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 to the office such loss and expense information as the office reasonably needs to meet this burden.

(11) 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)(a) It is the intent of the Legislature that insurers must 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 shall include, but not be limited to, fixtures or construction techniques which 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 which meet the minimum requirements of the Florida Building Code must be included in the rate filing. All insurance companies must make a rate filing which includes the credits, discounts, or other rate differentials or reductions in deductibles by February 28, 2003. By July 1, 2007, the office shall reevaluate the discounts, credits, other rate differentials, and appropriate reductions in deductibles for fixtures and construction techniques that meet the minimum requirements of the Florida Building Code, based upon actual experience or any other loss relativity studies available to the office. 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.

(b) By February 1, 2011, the Office of Insurance Regulation, in consultation with the Department of Financial Services and the Department of Community Affairs, shall develop and make publicly available a proposed method for insurers to establish discounts, credits, or other rate differentials for hurricane mitigation measures which directly correlate to the numerical rating assigned to a structure pursuant to the uniform home grading scale adopted by the Financial Services Commission pursuant to s. 215.55865, including any proposed changes to the uniform home grading scale. By October 1, 2011, the commission shall adopt rules requiring insurers to make rate filings for residential property insurance which revise insurers' discounts, credits, or other rate differentials for hurricane mitigation measures so that such rate differentials correlate directly to the uniform home grading scale. The rules may include such changes to the uniform home grading scale as the commission determines are necessary, and may specify the minimum required discounts, credits, or other rate differentials. Such rate differentials must be consistent with generally accepted actuarial principles and wind-loss mitigation studies. The rules shall allow a period of at least 2 years after the effective date of the revised mitigation discounts, credits, or other rate differentials for a property owner to obtain an inspection or otherwise qualify for the revised credit, during which time the insurer shall continue to apply the mitigation credit that was applied immediately prior to the effective date of the revised credit. Discounts, credits, and other rate differentials established for rate filings under this paragraph shall

supersede, after adoption, the discounts, credits, and other rate differentials included in rate filings under paragraph (a).

(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, in its sole discretion, implement an approved rate filing for residential property insurance over a period of years. An insurer electing to phase in its rate filing must provide an informational notice to the office setting out its schedule for implementation of the phased-in rate filing. An 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) EVALUATION OF RESIDENTIAL PROPERTY STRUCTURAL SOUNDNESS.--

(a) It is the intent of the Legislature to provide a program whereby homeowners may obtain an evaluation of the wind resistance of their homes with respect to preventing damage from hurricanes, together with a recommendation of reasonable steps that may be taken to upgrade their homes to better withstand hurricane force winds.

(b) To the extent that funds are provided for this purpose in the General Appropriations Act, the Legislature hereby authorizes the establishment of a program to be administered by the Citizens Property Insurance Corporation for homeowners insured in the high-risk account.

(c) The program shall provide grants to homeowners, for the purpose of providing homeowner applicants with funds to conduct an evaluation of the integrity of their homes with respect to withstanding hurricane force winds, recommendations to retrofit the homes to better withstand damage from such winds, and the estimated cost to make the recommended retrofits.

(d) The Department of Community Affairs shall establish by rule standards to govern the quality of the evaluation, the quality of the recommendations for retrofitting, the eligibility of the persons conducting the evaluation, and the selection of applicants under the program. In establishing the rule, the Department of Community Affairs shall consult with the advisory committee to minimize the possibility of fraud or abuse in the evaluation and retrofitting process, and to ensure that funds spent by homeowners acting on the recommendations achieve positive results.

(e) The Citizens Property Insurance Corporation shall identify areas of this state with the greatest wind risk to residential properties and recommend annually to the Department of Community Affairs priority target areas for such evaluations and inclusion with the associated residential construction mitigation program.

(9) 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.

10064	CITIZENS PROPERTY INSURANCE CORPORATION	FL	4,349,744,655	356,738,575	322,607,163	384,609,006	1,122,102
10739	STATE FARM FLORIDA INSURANCE COMPANY	FL	316,630,870	(49,663,360)	(74,955,684)	(177,830,765)	719,693
10861	UNIVERSAL PROPERTY & CASUALTY INSURANCE COMPANY	FL	106,714,632	18,887,219	(11,336,064)	(19,804,783)	562,973
11844	ST. JOHNS INSURANCE COMPANY, INC.	FL	44,388,395	37,881	(4,952,324)	(9,946,743)	181,837
25941	UNITED SERVICES AUTOMOBILE ASSOCIATION	TX	15,162,369,863	624,244,095	267,160,447	212,683,657	152,590
30511	CASTLE KEY INSURANCE COMPANY	IL	153,574,804	(2,053,204)	(10,920,693)	(21,604,580)	144,577
12196	ASI ASSURANCE CORP.	FL	32,967,097	1,835,012	1,678,319	923,355	126,727
10132	FLORIDA PENINSULA INSURANCE COMPANY	FL	62,035,089	(5,377,049)	(4,381,657)	(6,522,653)	113,041
10948	NATIONWIDE INSURANCE COMPANY OF FLORIDA	OH	269,677,576	(6,539,458)	(7,211,015)	(19,363,606)	103,999
12538	ROYAL PALM INSURANCE COMPANY	FL	40,750,218	(1,549,247)	(4,061,770)	(8,733,252)	103,484
12438	HOMEWISE INSURANCE COMPANY, INC.	FL	19,741,973	(520,199)	(1,039,676)	(1,183,643)	100,005
10835	CASTLE KEY INDEMNITY COMPANY	IL	14,369,265	268,788	268,788	-	97,457
10117	SECURITY FIRST INSURANCE COMPANY	FL	24,009,135	6,005,750	3,301,516	2,358,953	95,066
11986	UNIVERSAL INSURANCE COMPANY OF NORTH AMERICA	FL	38,062,995	8,144,089	234,803	(1,504,275)	94,734
12841	AMERICAN INTEGRITY INSURANCE COMPANY OF FLORIDA	FL	23,314,480	(3,003,886)	(3,663,649)	(5,280,367)	91,086
11027	TOWER HILL PRIME INSURANCE COMPANY	FL	32,970,672	1,833,358	5,759,834	2,594,504	84,950
10136	SOUTHERN FIDELITY INSURANCE COMPANY	FL	62,314,640	(959,217)	11,770	(1,945,763)	84,453
10872	AMERICAN STRATEGIC INSURANCE CORP.	FL	147,183,567	11,924,736	13,151,174	12,962,907	82,591
10688	FLORIDA FAMILY INSURANCE COMPANY	FL	21,064,192	1,413,994	1,587,349	774,608	82,107
23035	LIBERTY MUTUAL FIRE INSURANCE COMPANY	WI	1,171,451,940	98,576,941	49,357,390	(69,757,285)	81,635
10969	UNITED PROPERTY & CASUALTY INSURANCE COMPANY, INC.	FL	50,085,265	(259,544)	(3,937,884)	(5,632,367)	81,536
10111	AMERICAN BANKERS INSURANCE COMPANY OF FLORIDA	FL	417,079,987	36,666,798	50,098,849	47,130,845	81,101
10860	SUNSHINE STATE INSURANCE COMPANY	FL	13,518,710	1,414,182	886,883	1,312,377	79,783
25968	USAA CASUALTY INSURANCE COMPANY	TX	3,773,420,849	240,354,972	219,352,997	161,135,096	70,145
29050	TOWER HILL PREFERRED INSURANCE COMPANY	FL	29,797,718	691,136	361,622	(1,797,299)	63,975
12944	COMPANY	FL	29,516,123	5,398,989	(4,876,059)	(9,366,716)	63,006
13990	FIRST COMMUNITY INSURANCE COMPANY	FL	19,974,703	5,170	(233,700)	(688,164)	61,151
10953	CYPRESS PROPERTY & CASUALTY INSURANCE COMPANY	FL	34,890,402	(12,512,486)	(271,312)	(652,349)	57,068
12954	OLYMPUS INSURANCE COMPANY	FL	21,239,991	116,328	229,542	(909,611)	56,126
12247	SOUTHERN OAK INSURANCE COMPANY	FL	15,427,808	384,152	961,556	(730,608)	55,610
31216	FLORIDA FARM BUREAU CASUALTY INSURANCE COMPANY	FL	199,057,666	(126,170)	(478,382)	(7,761,848)	52,781
37478	HARTFORD INSURANCE COMPANY OF THE MIDWEST	IN	297,941,267	33,235,264	11,422,724	673,972	52,683
13142	ASI PREFERRED INSURANCE CORP.	FL	13,020,293	(495,542)	(484,059)	(992,650)	50,691
10908	CAPITOL PREFERRED INSURANCE COMPANY, INC.	FL	10,038,032	(1,483,764)	(752,905)	(1,099,830)	50,612
11185	FOREMOST INSURANCE COMPANY	MI	641,709,845	9,089,051	(4,508,500)	(44,612,508)	49,905
12359	AMERICAN TRADITIONS INSURANCE COMPANY	FL	8,863,951	(736,333)	(744,841)	(1,249,524)	49,385
12011	TOWER HILL SELECT INSURANCE COMPANY	FL	17,146,188	974,490	3,788,943	1,389,544	46,211
27980	FEDERATED NATIONAL INSURANCE COMPANY	FL	24,188,399	3,163,877	(5,341,318)	(12,429,305)	45,773
21817	FLORIDA FARM BUREAU GENERAL INSURANCE COMPANY	FL	8,612,113	94,024	94,024	(6,500)	44,598
10897	FIRST PROTECTIVE INSURANCE COMPANY	FL	15,860,776	947,242	404,079	50,825	40,698
12237	GULFSTREAM PROPERTY AND CASUALTY INSURANCE COMPANY	FL	18,756,090	(1,334,912)	442,724	(2,474,462)	38,213
38644	OMEGA INSURANCE COMPANY	FL	11,323,046	1,423,942	1,387,901	1,189,005	37,011
12957	MODERN USA INSURANCE COMPANY	FL	9,648,938	535,584	(1,267,688)	(2,111,389)	32,924
12582	HOMEWISE PREFERRED INSURANCE COMPANY	FL	6,907,373	(10,381,127)	(12,743,436)	(13,200,178)	32,144
11800	FOREMOST PROPERTY AND CASUALTY INSURANCE COMPANY	MI	16,472,511	167,991	134,752	(1,031,547)	31,732
17248	SAFEWAY PROPERTY INSURANCE COMPANY	IL	21,240,951	939,165	771,202	1,157,602	30,887
13125	PEOPLE'S TRUST INSURANCE COMPANY	FL	16,171,528	6,737,496	(5,750,992)	(5,949,170)	30,508
33588	FIRST LIBERTY INSURANCE CORPORATION (THE)	IL	21,959,038	167,892	180,892	(540,754)	29,852
20966	COTTON STATES MUTUAL INSURANCE COMPANY	GA	63,703,169	(239,745)	1,324,567	(2,581,505)	27,041
20281	FEDERAL INSURANCE COMPANY	IN	14,210,546,079	(110,975,054)	937,896,426	175,069,813	26,687
19976	AMICA MUTUAL INSURANCE COMPANY	RI	2,196,376,395	(37,740,404)	38,640,596	32,950,923	24,820
10647	FIRST FLORIDIAN AUTO AND HOME INSURANCE COMPANY	FL	222,009,120	(9,063,655)	15,051,998	12,773,235	24,293
12314	AMERICAN MODERN INSURANCE COMPANY OF FLORIDA, INC.	FL	7,539,798	396,463	304,561	418,322	24,285
10186	FIDELITY FIRE & CASUALTY COMPANY	FL	13,249,355	2,342,263	321,739	40,070	24,146
13038	ARK ROYAL INSURANCE COMPANY	FL	10,195,611	1,708,054	1,600,091	2,177,230	23,411
12813	AUTO CLUB INSURANCE COMPANY OF FLORIDA	FL	29,462,405	8,180,565	(1,165,511)	(1,875,820)	19,896
11142	UNITED CASUALTY INSURANCE COMPANY OF AMERICA	IL	8,897,616	182,966	176,602	(6,251)	18,888
12482	EDISON INSURANCE COMPANY	FL	4,045,783	45,783	4,785	(27,322)	18,846
10203	ARGUS FIRE & CASUALTY INSURANCE COMPANY	FL	6,223,307	(3,817,198)	(2,899,309)	(3,349,319)	18,567
10149	FIRST HOME INSURANCE COMPANY	FL	14,703,875	(3,175,827)	(4,181,487)	(6,554,391)	17,472
12563	SAFE HARBOR INSURANCE COMPANY	FL	8,845,274	262,969	166,124	296,022	17,032
19380	AMERICAN HOME ASSURANCE COMPANY	NY	5,676,446,083	(195,902,881)	503,296,991	(225,857,077)	16,302
22683	TEACHERS INSURANCE COMPANY	IL	112,786,761	4,720,652	4,473,078	(2,979,858)	14,473
40169	METROPOLITAN CASUALTY INSURANCE COMPANY	RI	47,423,127	844,424	845,341	-	13,214
41998	AMERICAN SOUTHERN HOME INSURANCE COMPANY	FL	29,900,206	1,961,283	1,650,351	837,072	13,034
21873	FIREMAN'S FUND INSURANCE COMPANY	CA	2,822,884,161	(224,775,162)	(105,841,391)	(286,795,740)	10,542
16578	COMPANY	NY	96,762,824	3,790,233	3,795,849	3,627,517	10,196
10677	CINCINNATI INSURANCE COMPANY	OH	3,537,036,749	(110,754,758)	57,647,542	(67,576,696)	10,015
13619	SAWGRASS MUTUAL INSURANCE COMPANY	FL	7,868,163	379,609	820,280	(276,365)	9,908
10190	SOUTHERN-OWNERS INSURANCE COMPANY	MI	163,436,061	(1,531,780)	(839,830)	(9,259,914)	9,745
16810	AMERICAN MERCURY INSURANCE COMPANY	OK	116,555,785	(2,281,214)	(3,156,747)	(11,107,759)	9,306
12157	COMPANION PROPERTY AND CASUALTY INSURANCE COMPANY	SC	206,136,903	6,471,072	841,747	(911,425)	8,470
11072	ACA HOME INSURANCE CORP.	FL	15,650,336	288,830	447,595	(17,571)	8,007
13687	PREPARED INSURANCE COMPANY	FL	9,062,983	(1,336,027)	(2,494,900)	(2,583,743)	7,871

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13139	AVATAR PROPERTY & CASUALTY INSURANCE COMPANY	FL	12,613,736	930,285	116,805	(1,084,064)	7,465
19615	AMERICAN RELIABLE INSURANCE COMPANY	AZ	114,089,351	(1,476,827)	4,881,909	1,476,062	6,550
23841	NEW HAMPSHIRE INSURANCE COMPANY	PA	1,480,591,517	71,209,703	47,957,223	(25,709,773)	6,291
37710	FIRST AMERICAN PROPERTY & CASUALTY INSURANCE COMPANY	CA	47,193,801	1,931,840	2,090,992	1,846,595	6,199
18163	COOPERATIVA DE SEGUROS MULTIPLES DE PUERTO RICO, INC.	PR	209,651,185	(3,643,215)	(1,204,480)	(10,718,475)	6,155
41459	ARMED FORCES INSURANCE EXCHANGE	KS	59,110,494	(7,358,733)	(4,592,503)	(7,448,553)	4,944
18600	USAA GENERAL INDEMNITY COMPANY	TX	222,291,668	15,254,126	13,593,274	-	4,438
43699	AMERICAN FEDERATION INSURANCE COMPANY	MI	15,758,371	111,464	112,854	(55,563)	3,463
18988	AUTO-OWNERS INSURANCE COMPANY	MI	5,728,860,747	26,194,674	55,871,301	(68,608,704)	3,303
12873	PRIVILEGE UNDERWRITERS RECIPROCAL EXCHANGE	FL	49,837,795	(140,333)	(3,205,566)	(1,969,286)	3,163
29068	IDS PROPERTY CASUALTY INSURANCE COMPANY	WI	412,461,570	7,076,553	26,886,245	11,270,814	3,013
21849	AMERICAN AUTOMOBILE INSURANCE COMPANY	MO	160,943,579	(841,946)	(675,042)	(9,523,796)	2,922
41513	FOREMOST SIGNATURE INSURANCE COMPANY	MI	18,854,221	158,444	143,675	(1,569,091)	2,918
42552	NOVA CASUALTY COMPANY	NY	89,576,545	2,330,339	236,487	-	2,868
12968	AMERICAN COASTAL INSURANCE COMPANY	FL	89,749,269	10,784,729	10,512,274	15,549,447	2,587
21261	ELECTRIC INSURANCE COMPANY	MA	412,727,788	5,664,545	10,957,679	(5,338,090)	2,341
40231	OLD DOMINION INSURANCE COMPANY	FL	28,427,161	589,997	541,350	-	1,787
11993	ENCOMPASS FLORIDIAN INSURANCE COMPANY	IL	5,883,368	72,666	72,666	-	1,643
12601	AMERICAN CAPITAL ASSURANCE CORP.	FL	61,156,575	(323,944)	1,084,764	337,137	1,643
11156	HOMESITE INSURANCE COMPANY OF FLORIDA	FL	9,259,857	632,630	780,610	953,602	1,580
25666	TRAVELERS INDEMNITY COMPANY OF AMERICA	CT	161,100,804	10,691,630	10,040,970	2,483,633	1,504
39217	QBE INSURANCE CORPORATION	PA	297,233,686	59,126,854	(16,461,897)	(28,642,538)	1,226
13021	UNITED FIRE AND CASUALTY COMPANY	IA	572,293,546	16,028,667	17,030,301	6,664,797	1,210
11996	ENCOMPASS FLORIDIAN INDEMNITY COMPANY	IL	5,883,204	72,670	72,670	-	960
13621	STAR & SHIELD INSURANCE EXCHANGE	FL	6,700,685	(1,272,624)	(1,503,286)	(1,516,669)	778
26417	ACE INSURANCE COMPANY OF THE MIDWEST	IN	54,041,176	1,001,050	829,481	156,879	760
16691	GREAT AMERICAN INSURANCE COMPANY	OH	1,493,086,309	60,020,664	238,490,935	112,239,405	726
10324	ADDISON INSURANCE COMPANY	IA	31,639,968	1,320,515	1,270,077	401,493	717
22578	HORACE MANN INSURANCE COMPANY	IL	152,519,870	10,162,608	15,615,232	6,438,505	699
18058	PHILADELPHIA INDEMNITY INSURANCE COMPANY	PA	1,679,086,696	31,953,074	124,956,862	97,564,446	626
20303	GREAT NORTHERN INSURANCE COMPANY	IN	439,078,896	(14,148,550)	32,556,875	9,037,219	601
36560	SERVICE INSURANCE COMPANY	FL	13,066,305	(355,314)	(380,318)	(664,903)	585
21865	ASSOCIATED INDEMNITY CORPORATION	CA	82,014,545	(332,579)	(175,400)	(3,803,230)	521
20974	SHIELD INSURANCE COMPANY	GA	22,386,425	(134,828)	334,776	(11,557)	507
31968	MERASTAR INSURANCE COMPANY	IL	14,349,774	149,049	319,655	(650)	501
42803	GUIDEONE ELITE INSURANCE COMPANY	IA	19,057,104	282,635	277,811	-	494
43575	INDEMNITY INSURANCE COMPANY OF NORTH AMERICA	PA	163,988,872	6,033,158	6,740,431	4,154,601	439
18767	CHURCH MUTUAL INSURANCE COMPANY	WI	386,940,746	(5,699,273)	3,022,348	(14,741,289)	420
26344	GREAT AMERICAN ASSURANCE COMPANY	OH	17,431,255	235,847	236,564	-	403
19909	CENTENNIAL INSURANCE COMPANY	NY	(1,602,835)	426,917	321,645	(1,132,800)	352
29424	HARTFORD CASUALTY INSURANCE COMPANY	IN	1,030,074,674	48,819,073	48,734,192	7,413,692	343
33898	AEGIS SECURITY INSURANCE COMPANY	PA	38,262,423	(1,233,204)	(531,728)	(1,696,640)	332
20346	PACIFIC INDEMNITY COMPANY	WI	2,230,630,971	30,459,215	142,005,253	42,734,874	282
24724	FIRST NATIONAL INSURANCE COMPANY OF AMERICA	WA	41,625,860	(39,039,600)	656,444	(2,226,313)	235
19895	ATLANTIC MUTUAL INSURANCE COMPANY	NY	(24,744,568)	361,937	(242,651)	(3,381,090)	225
32930	CAPACITY INSURANCE COMPANY	FL	5,224,824	(150,887)	(940,086)	(1,035,438)	196
15032	GUIDEONE MUTUAL INSURANCE COMPANY	IA	375,618,545	(1,950,106)	3,537,132	(10,800,230)	163
24112	WESTFIELD INSURANCE COMPANY	OH	668,879,584	14,241,926	39,947,268	(8,652,776)	159
22136	GREAT AMERICAN INSURANCE COMPANY OF NEW YORK	NY	61,277,196	1,056,782	1,179,558	-	142
10014	AFFILIATED FM INSURANCE COMPANY	RI	828,088,674	(125,339)	32,430,970	22,301,246	131
20397	VIGILANT INSURANCE COMPANY	NY	183,600,016	6,974,698	6,994,772	1,134,280	122
30104	HARTFORD UNDERWRITERS INSURANCE COMPANY	CT	678,794,834	32,881,787	39,388,158	5,391,776	109
19704	AMERICAN STATES INSURANCE COMPANY	IN	287,961,822	(353,798,970)	12,850,030	(21,149,981)	95
10178	FCCI INSURANCE COMPANY	FL	428,337,416	947,905	1,556,311	(20,251,506)	75
25623	PHOENIX INSURANCE COMPANY	CT	1,331,376,952	106,630,162	42,914,595	16,127,483	73
19682	HARTFORD FIRE INSURANCE COMPANY	CT	13,147,206,939	(43,011,880)	219,327,988	55,939,674	69
33472	FCCI COMMERCIAL INSURANCE COMPANY	FL	15,950,044	337,046	329,143	(93,895)	66
24988	SENTRY INSURANCE A MUTUAL COMPANY	WI	3,108,143,987	(5,964,421)	123,431,912	(37,248,671)	65
11853	RANCHERS AND FARMERS INSURANCE COMPANY	TX	4,799,354	(218,001)	(479,961)	(554,065)	59
16870	GRANADA INSURANCE COMPANY	FL	9,464,829	15,968	(156,297)	(498,051)	59
14559	GUIDEONE SPECIALTY MUTUAL INSURANCE COMPANY	IA	77,918,948	869,727	636,818	(2,905,376)	50
20443	CONTINENTAL CASUALTY COMPANY	IL	9,901,914,565	563,763,005	422,532,709	(371,090,023)	47
23779	NATIONWIDE MUTUAL FIRE INSURANCE COMPANY	OH	2,175,571,517	83,928,783	75,488,071	14,442,751	42
22292	HANOVER INSURANCE COMPANY (THE)	NH	1,747,585,041	10,469,107	(13,822,514)	(116,873,670)	37
16535	ZURICH AMERICAN INSURANCE COMPANY	NY	6,884,030,904	(533,119,713)	314,487,100	99,758,045	31
19720	AMERICAN ALTERNATIVE INSURANCE CORPORATION	DE	156,199,765	2,828,331	7,701,520	12,278,067	31
24767	ST. PAUL FIRE & MARINE INSURANCE COMPANY	MN	6,241,521,469	(349,832,635)	239,918,982	82,867,120	26
23787	NATIONWIDE MUTUAL INSURANCE COMPANY	OH	10,118,791,963	643,748,553	399,124,680	107,063,769	23
42978	AMERICAN SECURITY INSURANCE COMPANY	DE	855,391,182	100,991,239	168,274,651	201,567,538	22
26832	GREAT AMERICAN ALLIANCE INSURANCE COMPANY	OH	28,818,729	725,733	716,187	-	20
20648	EMPLOYERS FIRE INSURANCE COMPANY	MA	45,352,957	(7,159,827)	4,987,462	187,878	16
24732	GENERAL INSURANCE COMPANY OF AMERICA	WA	350,563,125	(197,434,960)	11,563,971	(25,602,609)	16
40045	STARNET INSURANCE COMPANY	DE	119,329,612	5,338,576	4,526,567	2,665,379	14
20427	AMERICAN CASUALTY COMPANY OF READING, PENNSYLVANIA	PA	122,013,581	13,962,478	1,216,303	-	13

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29459	TWIN CITY FIRE INSURANCE COMPANY	IN	322,549,247	17,310,352	17,526,026	2,021,916	12
38970	MARKEL INSURANCE COMPANY	IL	183,975,093	7,407,915	7,487,687	(4,617,251)	12
21482	FACTORY MUTUAL INSURANCE COMPANY	RI	6,073,304,226	(130,341,510)	192,833,776	158,616,306	11
25615	CHARTER OAK FIRE INSURANCE COMPANY	CT	252,726,098	24,095,411	17,172,990	4,096,382	11
25674	TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA	CT	101,072,053	5,190,274	4,480,992	1,161,200	11
24414	GENERAL CASUALTY COMPANY OF WISCONSIN	WI	517,499,418	(38,769,316)	34,713,167	2,983,330	10
39306	FIDELITY AND DEPOSIT COMPANY OF MARYLAND	MD	189,525,891	4,110,443	3,311,237	-	10
20478	NATIONAL FIRE INSURANCE COMPANY OF HARTFORD	IL	110,089,032	3,170,441	1,709,266	-	9
22667	ACE AMERICAN INSURANCE COMPANY	PA	2,137,619,033	126,821,555	131,780,964	75,588,116	9
19690	AMERICAN ECONOMY INSURANCE COMPANY	IN	208,836,036	(299,794,630)	11,099,129	(15,584,197)	8
22306	MASSACHUSETTS BAY INSURANCE COMPANY	NH	52,248,192	3,840,625	840,412	-	8
24791	ST. PAUL MERCURY INSURANCE COMPANY	MN	71,956,743	4,941,484	4,852,950	1,290,199	8
35289	CONTINENTAL INSURANCE COMPANY	PA	1,563,742,459	22,133,477	21,687,657	(6,599,524)	7
42331	GUIDEONE AMERICA INSURANCE COMPANY	IA	9,536,616	121,545	120,842	-	7
19224	ST. PAUL PROTECTIVE INSURANCE COMPANY	IL	247,466,479	9,711,047	9,582,677	1,870,788	6
20621	ONEBEACON AMERICA INSURANCE COMPANY	MA	262,777,826	(64,024,835)	11,235,653	2,054,134	6
23043	LIBERTY MUTUAL INSURANCE COMPANY	MA	11,808,460,734	(683,092,181)	1,867,543,076	(399,075,409)	6
24449	REGENT INSURANCE COMPANY	WI	45,390,292	(10,930,409)	1,722,746	975,750	6
25682	TRAVELERS INDEMNITY COMPANY OF CONNECTICUT	CT	366,640,880	21,465,126	12,588,051	4,418,934	6
11231	GENERALI - U. S. BRANCH	NY	24,491,324	(607,446)	(790,034)	(1,605,386)	5
21881	NATIONAL SURETY CORPORATION	IL	129,127,295	(2,975,615)	(2,734,646)	(15,207,671)	5
37877	NATIONWIDE PROPERTY AND CASUALTY INSURANCE COMPANY	OH	51,317,063	12,430,908	472,317	-	5
38261	HARTFORD INSURANCE COMPANY OF THE SOUTHEAST	CT	62,617,153	3,929,773	4,923,716	673,972	5
20494	TRANSPORTATION INSURANCE COMPANY	IL	81,561,601	50,382,354	624,456	-	4
20702	ACE FIRE UNDERWRITERS INSURANCE COMPANY	PA	65,254,604	1,404,832	1,227,313	415,459	4
21857	AMERICAN INSURANCE COMPANY (THE)	OH	363,459,654	(6,100,278)	(7,806,497)	(43,572,778)	4
25658	TRAVELERS INDEMNITY COMPANY	CT	7,600,653,810	(771,985,066)	295,943,521	74,621,103	3
26905	CENTURY NATIONAL INSURANCE COMPANY	CA	289,868,786	1,254,471	15,546,122	5,193,558	3
27154	ATLANTIC SPECIALTY INSURANCE COMPANY	NY	48,286,202	(3,865,857)	1,578,260	75,152	3
35300	ALLIANZ GLOBAL RISKS US INSURANCE COMPANY	CA	3,820,949,266	(29,348,586)	195,759,311	10,978,065	3
39926	SELECTIVE INSURANCE COMPANY OF THE SOUTHEAST	IN	70,416,561	1,239,042	2,071,481	(1,214,049)	3
40142	AMERICAN ZURICH INSURANCE COMPANY	IL	158,878,148	3,351,990	2,499,889	-	3
10069	HOUSING AUTHORITY PROPERTY INSURANCE, A MUTUAL COMPANY	VT	98,446,258	2,598,836	1,649,687	1,105,291	2
20362	MITSUI SUMITOMO INSURANCE COMPANY OF AMERICA	NY	262,325,631	9,009,615	12,477,744	(691,345)	2
20508	VALLEY FORGE INSURANCE COMPANY	PA	66,102,106	12,073,827	1,082,681	-	2
20613	SPARTA INSURANCE COMPANY	CT	249,032,884	(5,121,705)	(7,395,042)	(10,333,020)	2
10220	COMMONWEALTH INSURANCE COMPANY OF AMERICA	WA	23,090,051	(1,867,750)	(844,941)	(1,599,492)	1
13250	WORKMEN'S AUTO INSURANCE COMPANY	CA	22,564,847	(120,360)	(227,107)	(3,641,474)	1
21113	UNITED STATES FIRE INSURANCE COMPANY	DE	899,050,350	(156,426,827)	65,499,606	(22,896,090)	1
22551	MITSUI SUMITOMO INSURANCE USA INC.	NY	54,977,751	1,003,410	725,025	(77,225)	1
23396	AMERISURE MUTUAL INSURANCE COMPANY	MI	615,772,895	(4,588,010)	16,346,124	(21,044,244)	1
24074	OHIO CASUALTY INSURANCE COMPANY	OH	989,171,413	(347,000,273)	27,385,570	(56,771,002)	1
24775	ST. PAUL GUARDIAN INSURANCE COMPANY	MN	28,477,665	1,279,506	1,257,372	322,550	1
26247	AMERICAN GUARANTEE AND LIABILITY INSURANCE COMPANY	NY	165,087,655	4,157,019	3,431,999	-	1
27855	ZURICH AMERICAN INSURANCE COMPANY OF ILLINOIS	IL	39,998,132	893,275	847,938	-	1
12573	UNIVERSAL SPECIALTY INSURANCE COMPANY	FL	7,900,722	(886,912)	(962,407)	(1,397,661)	-
12904	TOKIO MARINE AND NICHIDO FIRE INS. CO., LTD. (US BRANCH)	NY	608,518,544	27,984,595	24,774,219	(224,287)	-
19232	ALLSTATE INSURANCE COMPANY	IL	14,886,099,328	(139,974,572)	578,345,582	220,646,828	-
27847	INSURANCE COMPANY OF THE WEST	CA	352,401,692	(2,159,214)	3,809,036	(12,731,211)	-
32700	OWNERS INSURANCE COMPANY	OH	895,758,627	2,243,622	6,679,132	(44,208,901)	-
42048	DIAMOND STATE INSURANCE COMPANY	IN	115,049,681	2,517,760	868,144	(149,688)	-

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