

# Appendix

## Important Statutes

## New Legislation

- **2006**
  1. 947 Long-Term Care Coverage
  2. 299 Travel-Limited Life Insurance
- **2007**
  1. 590 Health Maintenance Organization Contracts

## Memorandums

- **Long-Term Care Insurance**
  1. Training Requirements for Agents Selling, Soliciting or Negotiating Long-Term Care Insurance: DFS-10-2007 issued August 28, 2007
  2. Adoption of Amendments to Chapter 69O-157, F.A.C.: OIR-07-11M issued July 30, 2007
- **Health Maintenance Organization**
  1. HMO Contracts: OIR-07-009M issued July 9, 2007
- **All Life and Health Insurers**
  1. Freedom to Travel Act: OIR-06-13M issued July 6, 2006
  2. Use of Forms in Spanish Language: OIR-06-05M issued April 13, 2006

## Cover Sheet

## Cheat Sheet

## Sample Letter of Consent Order Approach

## 10 Mandated Benefits

## 52 Mandated Benefits

## IMPORTANT LIFE & HEALTH STATUTES AND RULES

STATUTE/RULE	KEYWORD (ALPHABETICAL ORDER)	CROSS REFERENCES				
<u>624.6403</u>	ACUPUNCTURE-Payment of acupuncture benefits.					
<u>627.456</u>	AGE or sex, Misstatement of					
<u>627.429</u>	AIDS, 627.429(4) Medical tests for HIV SEE ALSO>>	<u>627.6646</u>	<u>627.6265</u>			
<u>626.025</u>	AGENT REQUIREMENTS-comply with consumer protection laws					
<u>626.112</u>	AGENT REQUIREMENTS-License and appointment					
<u>627.481</u>	ANNUITIES, DONOR and Gift Annuities					
<u>627.471</u>	ANNUITIES, Reversionary SEE ALSO>>	<u>Definition</u>				
<u>627.4554</u>	ANNUITY Investments by Seniors - SUITABILITY					
<u>690-156.119</u>	APPLICATION in advertisements for Medicare Supplement					
<u>627.454</u>	APPLICATION -Entire contract; statements in application					
<u>627.4085</u>	APPLICATION-Insurer name, agent name, license identification number					
<u>627.639</u>	APPLICATION- signed by agent					
<u>627.408</u>	APPLICATION as evidence -	<u>624.428</u>	<u>627.454</u>	<u>627.639</u>	<u>627.4085</u>	<u>690-156.119</u>
<u>627.561</u>	APPLICATION to be made part of policy - GROUP LIFE					
<u>627.571</u>	ASSIGNMENT- Insured may assign -GROUP LIFE	<u>627.638</u>	<u>627.664</u>			
<u>627.422</u>	ASSIGNMENT of policies Life & Health	<u>627.638</u>	<u>627.664</u>			

STATUTE/RULE	KEYWORD (ALPHABETICAL ORDER)	CROSS REFERENCES				
<u>626.9641</u>	BILL OF RIGHTS -Policyholders bill of rights, (1), (a), (b), (c), (d)					
<u>690-163.008</u>	BILL OF RIGHTS - Rights and Treatment of Debtors. – CREDIT LIFE					
<u>627.659</u>	BLANKET HEALTH insurance; eligible groups.					
<u>627.660</u>	BLANKET HEALTH, Conditions and provisions of blanket health insurance policies					
<u>627.6417</u>	BREAST CANCER SEE ALSO>>	<u>627.64171</u>	<u>627.64172</u>	<u>627.6418</u>	<u>627.6419</u>	<u>627.66122</u>
<u>627.6415</u>	CHILDREN: Adopted and Foster Children HEALTH COVERAGE					
<u>627.6416</u>	CHILDREN: Child Health Supervision Services SEE ALSO>>	<u>627.6579</u>				
<u>627.6044</u>	CLAIMS, PAYMENT-Use of a specific methodology INDIVIDUAL HEALTH					
<u>627.6647</u>	CLAIMS EXPERIENCE-Group health-release of information to policy holder					
<u>627.647</u>	CLAIMS FORMS - Standard health claim form SEE ALSO>>	<u>690-161</u>				
<u>626.797</u>	CODE OF ETHICS					
<u>626.9541</u>	COLLATERAL BUSINESS-refusal to insure without 626.9541(x)					
<u>626.794</u>	COMMISSION - Sharing SEE ALSO>>	<u>626.753</u>	<u>626.838</u>			
<u>627.412</u>	CONTRACT PROVISIONS - GENERAL					
<u>627.452</u>	CONTRACT PROVISIONS - INDIVIDUAL LIFE AND ANNUITY					
<u>627.605</u>	CONTRACT PROVISIONS - INDIVIDUAL HEALTH					
<u>627.522</u>	CONTRACT PROVISIONS- INDUSTRIAL LIFE (provisions and prohibitions)					

STATUTE/RULE	KEYWORD (ALPHABETICAL ORDER)	CROSS REFERENCES				
<u>627.558</u>	CONTRACT PROVISIONS - GROUP LIFE					
<u>627.657</u>	CONTRACT PROVISIONS - GROUP HEALTH					
<u>627.6675</u>	CONVERSION-Termination of group coverage					
<u>627.662</u>	CONTRACT PROVISIONS - GROUP HEALTH - OTHER PROVISIONS APPLICABLE					
<u>627.4235</u>	COORDINATION OF BENEFITS – HEALTH					
<u>627.4234</u>	COST CONTAINMENT Health insurance					
<u>627.510</u>	DEATH CLAIM SETTLEMENT-Industrial Life- Within 60 days					
<u>627.461</u>	DEATH CLAIM SETTLEMENT be made upon proof of death, policy surrender					
<u>627.421</u>	DELIVERY of policy					
<u>627.4091</u>	DENIAL OF APPLICATION TO INSURE-Specific reasons for denial, etc.					
<u>627.65745</u>	DIABETES Treatment Services SEE ALSO>>	<u>627.6408</u>				
<u>627.4233</u>	DISABILITY-Total disability defined					
<u>627.469</u>	DIVIDENDS-Annuities-if participating-end of 3rd year					
<u>627.457</u>	DIVIDENDS -dividends not later than the end of the third policy year					
<u>627.508</u>	DIVIDENDS-Industrial Life-for participating policies-ascertain and apportion annually					
<u>627.481</u>	DONOR Annuities/Gift Annuities (Administered by Gary Mills in OIR)					
<u>627.6699</u>	EMPLOYEE Health Care Access Act, 3(d)(k), (4), (5), (6), (7), (12), (13), (15)					

STATUTE/RULE	KEYWORD (ALPHABETICAL ORDER)	CROSS REFERENCES				
<u>627.6563</u>	EMPLOYMENT, Full Time Defined					
<u>627.6472</u>	EXCLUSIVE PROVIDER ORGANIZATIONS – EPO SEE ALSO>>	<u>627.6473</u>				
<u>627.64725</u>	Health maintenance organization or exclusive provider organization;					
<u>627.452(4)</u>	FONT SIZE-627.452(4) and Standard provisions required-LIFE Insurance					
<u>690-191.051</u>	FORM NUMBERS- Approval of Subscriber Contract and Related Forms for HMOs					
<u>690-149.021</u>	FORM NUMBERS- Form filing procedures					
<u>817.234(1)(b)</u>	FRAUD Statement on applications 817.234(1)(b)					
<u>626.99(4)(a)</u>	FREE LOOK-Ten Day Free Look – Life					
<u>627.4301</u>	GENETIC INFORMATION for Health Insurance Purposes SEE ALSO>>	<u>627.6561 (3)</u>	<u>627.65625</u>			
<u>627.453</u>	GRACE PERIOD-30 Days-Life insurance & annuities					
<u>627.465</u>	GRACE PERIOD-Annuities-30 days, optional 6% maximum interest charge for late payments					
<u>627.504</u>	GRACE PERIOD-Industrial Life-4 weeks for weekly premiums and 30 days for monthly premiums					
<u>627.5565</u>	GROUP LIFE Additional Groups - General provisions					
<u>627.656</u>	GROUP HEALTH - Additional Groups					
<u>627.6487</u>	GUARANTEED ISSUE-availability of individual health insurance	<u>690-154-110</u>	<u>690-154.302+</u>			
<u>627.6402</u>	HEALTHY LIFESTYLES-Insurance rebates	<u>627.65626</u>	<u>627.65625(4)(b)(2)</u>			
<u>627.429</u>	HIV infection and AIDS for insurance purposes, Medical test for 627.429(4)(e)					

STATUTE/RULE	KEYWORD (ALPHABETICAL ORDER)	CROSS REFERENCES				
<u>627.472</u>	INCONTESTABILITY after reinstatement limited to 2 years	<u>817.234(1)(b)</u>				
<u>627.466</u>	INCONTESTABILITY-Annuities-after 2 years from issue date	<u>817.234(1)(b)</u>				
<u>627.506</u>	INCONTESTABILITY-Industrial Life- after 2 years	<u>817.234(1)(b)</u>				
<u>627.455</u>	INCONTESTABILITY-Life	<u>817.234(1)(b)</u>				
<u>627.560</u>	INCONTESTABILITY-Life-GROUP (two years from issue date) GROUP Life	<u>817.234(1)(b)</u>				
<u>627.481</u>	INSURABLE INTEREST-Donor Annuities					
<u>627.404</u>	INSURABLE INTEREST- Not required in Florida Law for personal life insurance if adult.	<u>627.631</u>				
<u>627.406</u>	INSURABLE INTEREST- Age 15-Insurable interest must exist if .... SEE	<u>627.631</u>				
<u>627.631</u>	INSURABLE INTEREST- Third Party Ownership (Health)	<u>627.404</u>	<u>627.406</u>			
<u>627.562</u>	INSURABILITY requirements (Late enrollees and excess amounts) GROUP LIFE					
<u>624.02</u>	INSURANCE (general definition)					
<u>624.03</u>	INSURANCE COMPANY (general definition)					
<u>627.4585</u>	INTEREST PAYABLE on policy loans may not exceed 10% or Moody's Index					
<u>627.482</u>	INTEREST PAYABLE on cash surrender of policy", "625.121.(6) (e)"	<u>625.121(6)(e)</u>				
<u>627.4615</u>	INTEREST PAYABLE on death claim payments					
<u>624.602</u>	LIFE INSURANCE, life insurance company also defined					
<u>95.11(2)(b)</u>	LEGAL ACTIONS limitation-must file within 5 years					

STATUTE/RULE	KEYWORD (ALPHABETICAL ORDER)	CROSS REFERENCES				
<u>627.6612</u>	MASTECTOMY-Coverage for surgical procedures and devices incident to mastectomy.	<u>627.6417</u>				
<u>627.6574</u>	MATERNITY CARE-Can't limit hosp stay					
<u>627.6571</u>	MODIFICATION - Guaranteed renewal of coverage					
<u>627.637</u>	NON-COMPLYING CONTRACTS SEE ALSO>>	<u>627.418</u>	<u>626.141</u>			
<u>627.6575</u>	NEWBORN - Coverage of newborn children	<u>627.641</u>				
<u>627.476(2)(a)</u>	NONFORFEITURE Law for Life Insurance-Standard					
<u>624.04</u>	PERSON defined See also 1.01. F.S. as reference in Viatical definitions					
<u>627.4556</u>	POLICY LOAN - Automatic Policy Loan Provision - Life Insurance					
<u>627.458</u>	POLICY LOAN must be guaranteed in an amount equal to the cash value-whole life					
<u>627.403</u>	PREMIUM defined					
<u>627.4145 (1)</u>	READABILITY - Readable language in insurance policies					
<u>626.572</u>	REBATING; when allowed					
<u>627.509</u>	REINSTATEMENT-Industrial Life-within 3 years of default; maximum of 6% interest on overdue payments					
<u>627.459</u>	REINSTATEMENT-within 3 years of default; maximum of 6% interest on overdue payments					
<u>627.6571</u>	RENEWAL of coverage-Guaranteed [note: see doi memorandum 99-104m], group health insurance policy					
<u>690-151.006.007</u>	REPLACEMENT procedures					
<u>690-151.005</u>	REPLACEMENT question for applicant and agent					

STATUTE/RULE	KEYWORD (ALPHABETICAL ORDER)	CROSS REFERENCES				
<u>624.308</u>	RULES, Power of the Department and Commission to make rules					
<u>627.4555</u>	SECONDARY ADDRESSEE					
<u>627.416</u>	SIGNATURE of officer of the company-Form must contain					
<u>626.112</u>	SOLICITATION of insurance - license and appointment required					
<u>624.406(1)(4)</u>	STOP LOSS - EXCESS INSURANCE					
<u>627.4554</u>	SUITABILITY - ANNUITY Investments by Seniors -					
<u>627.4131</u>	TELEPHONE NUMBER required, last three words of section.					
<u>626.951</u>	UNFAIR TRADE PRACTICES	<u>641.3903</u>	<u>636.059</u>			
<u>668.50</u>	Uniform Electronic Transaction Act. (UETA)					
<u>627.418</u>	VALIDITY of non-complying contracts-Insurance Rates and Contracts					
<u>636.025</u>	VALIDITY of non-complying contracts - Prepaid Limited Health Service Organizations					
<u>641.3105</u>	VALIDITY of non-complying contracts- HMOs					
<u>626.9911</u>	VIATICAL SETTLEMENTS - Definitions					



## IMPORTANT LIFE & HEALTH STATUTES AND RULES (Continued)

### STATUTES

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

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

1. An insurer may not refuse life insurance to; refuse to continue the life insurance of; or limit the amount, extent, or kind of life insurance coverage available to an individual based solely on the individual's past lawful foreign travel experiences.
2. An insurer may not refuse life insurance to; refuse to continue the life insurance of; or limit the amount, extent, or kind of life insurance coverage available to an individual based solely on the individual's future lawful travel plans unless the insurer can demonstrate and the Office of Insurance Regulation determines that:
  - a. Individuals who travel are a separate actuarially supportable class whose risk of loss is different from those individuals who do not travel; and
  - b. Such risk classification is based upon sound actuarial principles and actual or reasonably anticipated experience that correlates to the risk of travel to a specific destination.
3. The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 necessary to implement this paragraph and may provide for limited exceptions that are based upon national or international emergency conditions that affect the public health, safety, and welfare and that are consistent with public policy.
4. Each market conduct examination of a life insurer conducted pursuant to s. 624.3161 shall include a review of every application under which such insurer refused to issue life insurance; refused to continue life insurance; or limited the amount, extent, or kind of life insurance issued, based upon future lawful travel plans.
5. The administrative fines provided in s. 624.4211(2) and (3) shall be trebled for violations of this paragraph.
6. The Office of Insurance Regulation shall report to the President of the Senate and the Speaker of the House of Representatives by March 1, 2007, and on the same date annually thereafter, on the implementation of this paragraph. The report shall include, but not be limited to, the number of applications under which life insurance was denied, continuance was refused, or coverage was limited based on future travel plans; the number of insurers taking such action; and the reason for taking each such action.

**626.9541(s)(t)**

*(s) Prohibited arrangements as to funerals.--*

1. No life insurer shall designate in any life insurance policy the person to conduct the funeral of the insured, or organize, promote, or operate any enterprise or plan to enter into any contract with any insured under which the freedom of choice in the open market of the person having the legal right to such choice is restricted as to the purchase, arrangement, and conduct of a funeral service or any part thereof for any individual insured by the insurer. No life insurer shall designate in any life insurance policy the person to conduct the funeral of the insured as the owner of the policy.
2. No insurer shall contract or agree to furnish funeral merchandise or services in connection with the disposition of any person upon the death of any person insured by such insurer.
3. No insurer shall contract or agree with any funeral director or direct disposer to the effect that such funeral director or direct disposer shall conduct the funeral of any person insured by such insurer.
4. No insurer shall provide, in any insurance contract covering the life of any person in this state, for the payment of the proceeds or benefits thereof in other than legal tender of the United States and of this state, or for the withholding of such proceeds or benefits, all for the purpose of either directly or indirectly providing, inducing, or furthering any arrangement or agreement designed to require or induce the employment of a particular person to conduct the funeral of the insured.

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

1. No life insurer shall permit any funeral director or direct disposer to act as its representative, adjuster, claim agent, special claim agent, or agent for such insurer in soliciting, negotiating, or effecting contracts of life insurance on any plan or of any nature issued by such insurer or in collecting premiums for holders of any such contracts except as prescribed in s. 626.785(3).
2. No life insurer shall:
  - a. Affix, or permit to be affixed, advertising matter of any kind or character of any licensed funeral director or direct disposer to such policies of insurance.
  - b. Circulate, or permit to be circulated, any such advertising matter with such insurance policies.
  - c. Attempt in any manner or form to influence policyholders of the insurer to employ the services of any particular licensed funeral director or direct disposer.
3. No such insurer shall maintain, or permit its agent to maintain, an office or place of business in the office, establishment, or place of business of any funeral director or direct disposer in this state.

**626.9911 Definitions:**

- (1) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, or purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any entity that has direct ownership in a policy or certificate that is the subject of a viatical settlement contract, but whose principal activity related to the transaction is providing funds or credit

enhancement to effect the viatical settlement or the purchase of one or more viaticated policies and who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts. The term does not include a nonaccredited investor or other natural person. A financing entity may not enter into a viatical settlement contract.

(2) "Independent third-party trustee or escrow agent" means an attorney, certified public accountant, financial institution, or other person providing escrow services under the authority of a regulatory body. The term does not include any person associated, affiliated, or under common control with a viatical settlement provider or viatical settlement broker.

(3) "Life expectancy" means an opinion or evaluation as to how long a particular person is to live, or relating to such person's expected demise.

(4) "Life expectancy provider" means a person who determines, or holds himself or herself out as determining, life expectancies or mortality ratings used to determine life expectancies:

(a) On behalf of a viatical settlement provider, viatical settlement broker, life agent, or person engaged in the business of viatical settlements;

(b) In connection with a viatical settlement investment, pursuant to s. 517.021(23); or

(c) On residents of this state in connection with a viatical settlement contract or viatical settlement investment.

(5) "Person" has the meaning specified in s. 1.01.

(6) "Related form" means any form, created by or on behalf of a licensee, which a viator is required to sign or initial. The forms include, but are not limited to, a power of attorney, a release of medical information form, a suitability questionnaire, a disclosure document, or any addendum, schedule, or amendment to a viatical settlement contract considered necessary by a provider to effectuate a viatical settlement transaction.

(7) "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust must have a written agreement with a licensed viatical settlement provider or financing entity under which the licensed viatical settlement provider or financing entity is responsible for insuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to viatical settlement transactions available to the office as if those records and files were maintained directly by the licensed viatical settlement provider. This term does not include an independent third-party trustee or escrow agent or a trust that does not enter into agreements with a viator. A related provider trust shall be subject to all provisions of this act that apply to the viatical settlement provider who established the related provider trust, except s. 626.9912, which shall not be applicable. A viatical settlement provider may establish no more than one related provider trust, and the sole trustee of such related provider trust shall be the viatical settlement provider licensed under s. 626.9912. The name of the licensed viatical settlement provider shall be included within the name of the related provider trust.

(8) "Special purpose entity" means an entity established by a licensed viatical settlement provider or by a financing entity, which may be a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide, either directly or indirectly, access to institutional capital markets to a viatical settlement provider or financing entity. A special

purpose entity may not obtain capital from any natural person or entity with less than \$50 million in assets and may not enter into a viatical settlement contract.

(9) "Viatical settlement broker" means a person who, on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator resident in this state and one or more viatical settlement providers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. The term does not include an attorney, licensed Certified Public Accountant, or investment adviser lawfully registered under chapter 517, who is retained to represent the viator and whose compensation is paid directly by or at the direction and on behalf of the viator.

(10) "Viatical settlement contract" means a written agreement entered into between a viatical settlement provider, or its related provider trust, and a viator. The viatical settlement contract includes an agreement to transfer ownership or change the beneficiary designation of a life insurance policy at a later date, regardless of the date that compensation is paid to the viator. The agreement must establish the terms under which the viatical settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of all or a portion of the insurance policy or certificate of insurance to the viatical settlement provider. A viatical settlement contract also includes a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy.

(11) "Viatical settlement investment" has the same meaning as specified in s. 517.021.

(12) "Viatical settlement provider" means a person who, in this state, from this state, or with a resident of this state, effectuates a viatical settlement contract. The term does not include:

(a) Any bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan.

(b) A life and health insurer that has lawfully issued a life insurance policy that provides accelerated benefits to terminally ill policyholders or certificateholders.

(c) Any natural person who enters into no more than one viatical settlement contract with a viator in 1 calendar year, unless such natural person has previously been licensed under this act or is currently licensed under this act.

(d) A trust that meets the definition of a "related provider trust."

(e) A viator in this state.

(f) A financing entity.

(13) "Viaticated policy" means a life insurance policy, or a certificate under a group policy, which is the subject of a viatical settlement contract.

(14) "Viator" means the owner of a life insurance policy or a certificateholder under a group policy, which policy is not a previously viaticated policy, who enters or seeks to enter into a viatical settlement contract. This term does not include a viatical settlement provider or any person acquiring a policy or interest in a policy from a viatical settlement provider, nor does it include an independent third-party trustee or escrow agent.

**627.4555 Secondary notice**--Except as provided in this section, a contract for life insurance issued or issued for delivery in this state on or after October 1, 1997, covering a natural person 64 years of age or older, which has been in force for at least 1 year, may not be lapsed for nonpayment of premium unless, after expiration of the grace period, and at least 21 days before the effective date of any such lapse, the insurer has mailed a notification of the impending lapse in coverage to the policyowner and to a specified secondary addressee if such addressee has been designated in writing by name and address by the policyowner. An insurer issuing a life insurance contract on or after October 1, 1997, shall notify the applicant of the right to designate a secondary addressee at the time of application for the policy, on a form provided by the insurer, and at any time the policy is in force, by submitting a written notice to the insurer containing the name and address of the secondary addressee. For purposes of any life insurance policy that provides a grace period of more than 51 days for nonpayment of premiums, the notice of impending lapse in coverage required by this section must be mailed to the policyowner and the secondary addressee at least 21 days before the expiration of the grace period provided in the policy. This section does not apply to any life insurance contract under which premiums are payable monthly or more frequently and are regularly collected by a licensed agent or are paid by credit card or any preauthorized check processing or automatic debit service of a financial institution.

**627.603 Death benefits**--Any health insurance policy may contain a provision for paying a benefit for death from any cause in an amount not exceeding \$1,000, which benefit shall not relieve such policy from the requirements of this chapter. This provision shall not limit benefits for death by accident.

#### **668.50 Uniform Electronic Transaction Act.—**

- (1) **SHORT TITLE.**--This section may be cited as the "Uniform Electronic Transaction Act."
- (2) **DEFINITIONS.**--As used in this section:
  - (a) "Agreement" means the bargain of the parties in fact, as found in their language or inferred from other circumstances and from rules, regulations, and procedures given the effect of agreements under provisions of law otherwise applicable to a particular transaction.
  - (b) "Automated transaction" means a transaction conducted or performed, in whole or in part, by electronic means or electronic records, in which the acts or records of one or both parties are not reviewed by an individual in the ordinary course in forming a contract, performing under an existing contract, or fulfilling an obligation required by the transaction.
  - (c) "Computer program" means a set of statements or instructions to be used directly or indirectly in an information processing system in order to bring about a certain result.
  - (d) "Contract" means the total legal obligation resulting from the parties' agreement as affected by this act and other applicable provisions of law.
  - (e) "Electronic" means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

- (f) "Electronic agent" means a computer program or an electronic or other automated means used independently to initiate an action or respond to electronic records or performances in whole or in part, without review or action by an individual.
- (g) "Electronic record" means a record created, generated, sent, communicated, received, or stored by electronic means.
- (h) "Electronic signature" means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.
- (i) "Governmental agency" means an executive, legislative, or judicial agency, department, board, commission, authority, institution, or instrumentality of this state, including a county, municipality, or other political subdivision of this state and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency.
- (j) "Information" means data, text, images, sounds, codes, computer programs, software, databases, or other similar representations of knowledge.
- (k) "Information processing system" means an electronic system for creating, generating, sending, receiving, storing, displaying, or processing information.
- (l) "Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, governmental agency, public corporation, or any other legal or commercial entity.
- (m) "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form, including public records as defined in s. 119.011.
- (n) "Security procedure" means a procedure employed for the purpose of verifying that an electronic signature, record, or performance is that of a specific person or for detecting changes or errors in the information in an electronic record. The term includes a procedure that requires the use of algorithms or other codes, identifying words or numbers, encryption, or callback or other acknowledgment procedures.
- (o) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States. The term includes an Indian tribe or band, or Alaskan native village, which is recognized by federal law or formally acknowledged by a state.
- (p) "Transaction" means an action or set of actions occurring between two or more persons relating to the conduct of business, commercial, insurance, or governmental affairs.
- (3) SCOPE.--
- (a) Except as otherwise provided in paragraph (b), this section applies to electronic records and electronic signatures relating to a transaction.
- (b) This section does not apply to a transaction to the extent the transaction is governed by:
1. A provision of law governing the creation and execution of wills, codicils, or testamentary trusts;
  2. The Uniform Commercial Code other than s. 671.107 and chapters 672 and 680;
  3. The Uniform Computer Information Transactions Act; or
  4. Rules relating to judicial procedure.
- (c) This section applies to an electronic record or electronic signature otherwise excluded under paragraph (b) to the extent such record or signature is governed by a provision of law other than those specified in paragraph (b).

- (d) A transaction subject to this section is also subject to other applicable provisions of substantive law.
- (4) **PROSPECTIVE APPLICATION.**--This section applies to any electronic record or electronic signature created, generated, sent, communicated, received, or stored on or after July 1, 2000.
- (5) **USE OF ELECTRONIC RECORDS AND ELECTRONIC SIGNATURES; VARIATION BY AGREEMENT.**--
- (a) This section does not require a record or signature to be created, generated, sent, communicated, received, stored, or otherwise processed or used by electronic means or in electronic form.
- (b) This section applies only to transactions between parties each of which has agreed to conduct transactions by electronic means. Whether the parties agree to conduct a transaction by electronic means is determined from the context and surrounding circumstances, including the parties' conduct.
- (c) A party that agrees to conduct a transaction by electronic means may refuse to conduct other transactions by electronic means. The right granted by this paragraph may not be waived by agreement.
- (d) Except as otherwise provided in this section, the effect of any provision of this section may be varied by agreement. The presence in certain provisions of this section of the words "unless otherwise agreed," or words of similar import, does not imply that the effect of other provisions may not be varied by agreement.
- (e) Whether an electronic record or electronic signature has legal consequences is determined by this section and other applicable provisions of law.
- (6) **CONSTRUCTION AND APPLICATION.**--This section shall be construed and applied to:
- (a) Facilitate electronic transactions consistent with other applicable provisions of law.
- (b) Be consistent with reasonable practices concerning electronic transactions and with the continued expansion of those practices.
- (c) Effectuate its general purpose to make uniform the law with respect to the subject of this section among states enacting similar legislation.
- (7) **LEGAL RECOGNITION OF ELECTRONIC RECORDS, ELECTRONIC SIGNATURES, AND ELECTRONIC CONTRACTS.**--
- (a) A record or signature may not be denied legal effect or enforceability solely because the record or signature is in electronic form.
- (b) A contract may not be denied legal effect or enforceability solely because an electronic record was used in the formation of the contract.
- (c) If a provision of law requires a record to be in writing, an electronic record satisfies such provision.
- (d) If a provision of law requires a signature, an electronic signature satisfies such provision.
- (8) **PROVISION OF INFORMATION IN WRITING; PRESENTATION OF RECORDS.**--
- (a) If parties have agreed to conduct a transaction by electronic means and a provision of law requires a person to provide, send, or deliver information in writing to another person, the requirement is satisfied if the information is provided, sent, or delivered, as the case may be, in an electronic record capable of retention by the recipient at the time of receipt. An electronic record is not capable of retention by the recipient if the sender or the sender's information processing system inhibits the ability of the recipient to print or store the electronic record.

(b) If a provision of law other than this section requires a record to be posted or displayed in a certain manner; to be sent, communicated, or transmitted by a specified method; or to contain information that is formatted in a certain manner, the following rules apply:

1. The record must be posted or displayed in the manner specified in the other provision of law.
2. Except as otherwise provided in subparagraph (d)2., the record must be sent, communicated, or transmitted by the method specified in the other provision of law.
3. The record must contain the information formatted in the manner specified in the other provision of law.

(c) If a sender inhibits the ability of a recipient to store or print an electronic record, the electronic record is not enforceable against the recipient.

(d) The requirements of this section may not be varied by agreement, provided:

1. To the extent a provision of law other than this section requires information to be provided, sent, or delivered in writing but permits that requirement to be varied by agreement, the requirement under paragraph (a) that the information be in the form of an electronic record capable of retention may also be varied by agreement.
2. A requirement under a law other than this section to send, communicate, or transmit a record by first-class mail, postage prepaid, or other regular United States mail, may be varied by agreement to the extent permitted by the other provision of law.

**(9) ATTRIBUTION AND EFFECT OF ELECTRONIC RECORD AND ELECTRONIC SIGNATURE.--**

(a) An electronic record or electronic signature is attributable to a person if the record or signature was the act of the person. The act of the person may be shown in any manner, including a showing of the efficacy of any security procedure applied to determine the person to which the electronic record or electronic signature was attributable.

(b) The effect of an electronic record or electronic signature attributed to a person under paragraph (a) is determined from the context and surrounding circumstances at the time of its creation, execution, or adoption, including the parties' agreement, if any, and otherwise as provided by law.

**(10) EFFECT OF CHANGE OR ERROR.--**If a change or error in an electronic record occurs in a transmission between parties to a transaction, the following rules apply:

(a) If the parties have agreed to use a security procedure to detect changes or errors and one party has conformed to the procedure, but the other party has not, and the nonconforming party would have detected the change or error had that party also conformed, the conforming party may avoid the effect of the changed or erroneous electronic record.

(b) In an automated transaction involving an individual, the individual may avoid the effect of an electronic record that resulted from an error made by the individual in dealing with the electronic agent of another person if the electronic agent did not provide an opportunity for the prevention or correction of the error and, at the time the individual learns of the error, the individual:

1. Promptly notifies the other person of the error and that the individual did not intend to be bound by the electronic record received by the other person.
2. Takes reasonable steps, including steps that conform to the other person's reasonable instructions, to return to the other person or, if instructed by the other person, to destroy the consideration received, if any, as a result of the erroneous electronic record.



3. Has not used or received any benefit or value from the consideration, if any, received from the other person.

(c) If paragraphs (a) and (b) do not apply, the change or error has the effect provided by the other provision of law, including the law of mistake, and the parties' contract, if any.

(d) Paragraphs (b) and (c) may not be varied by agreement.

(11) NOTARIZATION AND ACKNOWLEDGMENT.--

(a) If a law requires a signature or record to be notarized, acknowledged, verified, or made under oath, the requirement is satisfied if the electronic signature of the person authorized by applicable law to perform those acts, together with all other information required to be included by other applicable law, is attached to or logically associated with the signature or record.

Neither a rubber stamp nor an impression type seal is required for an electronic notarization.

(b) A first-time applicant for a notary commission must submit proof that the applicant has, within 1 year prior to the application, completed at least 3 hours of interactive or classroom instruction, including electronic notarization, and covering the duties of the notary public.

Courses satisfying this section may be offered by any public or private sector person or entity registered with the Executive Office of the Governor and must include a core curriculum approved by that office.

(12) RETENTION OF ELECTRONIC RECORDS; ORIGINALS.--

(a) If a law requires that a record be retained, the requirement is satisfied by retaining an electronic record of the information in the record which:

1. Accurately reflects the information set forth in the record after the record was first generated in final form as an electronic record or otherwise.

2. Remains accessible for later reference.

(b) A requirement to retain a record in accordance with paragraph (a) does not apply to any information the sole purpose of which is to enable the record to be sent, communicated, or received.

(c) A person may satisfy paragraph (a) by using the services of another person if the requirements of paragraph (a) are satisfied.

(d) If a provision of law requires a record to be presented or retained in its original form, or provides consequences if the record is not presented or retained in its original form, that law is satisfied by an electronic record retained in accordance with paragraph (a).

(e) If a provision of law requires retention of a check, that requirement is satisfied by retention of an electronic record of the information on the front and back of the check in accordance with paragraph (a).

(f) A record retained as an electronic record in accordance with paragraph (a) satisfies a provision of law requiring a person to retain a record for evidentiary, audit, or similar purposes, unless a provision of law enacted after July 1, 2000, specifically prohibits the use of an electronic record for the specified purpose.

(g) This section does not preclude a governmental agency of this state from specifying additional requirements for the retention of a record subject to the agency's jurisdiction.

(13) ADMISSIBILITY IN EVIDENCE.--In a proceeding, evidence of a record or signature may not be excluded solely because the record or signature is in electronic form.

(14) AUTOMATED TRANSACTIONS.--In an automated transaction, the following rules apply:

(a) A contract may be formed by the interaction of electronic agents of the parties, even if no individual was aware of or reviewed the electronic agents' actions or the resulting terms and agreements.

(b) A contract may be formed by the interaction of an electronic agent and an individual, acting on the individual's own behalf or for another person, including by an interaction in which the individual performs actions that the individual is free to refuse to perform and which the individual knows or has reason to know will cause the electronic agent to complete the transaction or performance.

(c) The terms of the contract are determined by the substantive law applicable to the contract.

**(15) TIME AND PLACE OF SENDING AND RECEIVING.--**

(a) Unless otherwise agreed between the sender and the recipient, an electronic record is sent when the record:

1. Is addressed properly or otherwise directed properly to an information processing system that the recipient has designated or uses for the purpose of receiving electronic records or information of the type sent and from which the recipient is able to retrieve the electronic record.
2. Is in a form capable of being processed by that system.
3. Enters an information processing system outside the control of the sender or of a person that sent the electronic record on behalf of the sender or enters a region of the information processing system designated or used by the recipient which is under the control of the recipient.

(b) Unless otherwise agreed between a sender and the recipient, an electronic record is received when the record enters an information processing system that the recipient has designated or uses for the purpose of receiving electronic records or information of the type sent and from which the recipient is able to retrieve the electronic record; and is in a form capable of being processed by that system.

(c) Paragraph (b) applies even if the place the information processing system is located is different from the place the electronic record is deemed to be received under paragraph (d).

(d) Unless otherwise expressly provided in the electronic record or agreed between the sender and the recipient, an electronic record is deemed to be sent from the sender's place of business and to be received at the recipient's place of business. For purposes of this paragraph, the following rules apply:

1. If the sender or recipient has more than one place of business, the place of business of that person is the place having the closest relationship to the underlying transaction.
2. If the sender or the recipient does not have a place of business, the place of business is the sender's or recipient's residence, as the case may be.

(e) An electronic record is received under paragraph (b) even if no individual is aware of its receipt.

(f) Receipt of an electronic acknowledgment from an information processing system described in paragraph (b) establishes that a record was received but, by itself, does not establish that the content sent corresponds to the content received.

(g) If a person is aware that an electronic record purportedly sent under paragraph (a), or purportedly received under paragraph (b), was not actually sent or received, the legal effect of the sending or receipt is determined by other applicable provisions of law. Except to the extent permitted by the other provisions of law, the requirements of this paragraph may not be varied by agreement.

(h) An automated transaction does not establish the acceptability of an electronic record for recording purposes.

**(16) TRANSFERABLE RECORDS.--**

(a) For purposes of this paragraph, "transferable record" means an electronic record that:

1. Would be a note under chapter 673, or a document under chapter 677, if the electronic record were in writing.

2. The issuer of the electronic record expressly has agreed is a transferable record.

(b) A person has control of a transferable record if a system employed for evidencing the transfer of interests in the transferable record reliably establishes that person as the person to which the transferable record was issued or transferred.

(c) A system satisfies paragraph (b), and a person is deemed to have control of a transferable record, if the transferable record is created, stored, and assigned in such a manner that:

1. A single authoritative copy of the transferable record exists which is unique, identifiable, and, except as otherwise provided in subparagraphs 4., 5., and 6., unalterable.

2. The authoritative copy identifies the person asserting control as the person to which the transferable record was issued or, if the authoritative copy indicates that the transferable record has been transferred, the person to which the transferable record was most recently transferred.

3. The authoritative copy is communicated to and maintained by the person asserting control or its designated custodian.

4. Copies or revisions that add or change an identified assignee of the authoritative copy can be made only with the consent of the person asserting control.

5. Each copy of the authoritative copy and any copy of a copy is readily identifiable as a copy that is not the authoritative copy.

6. Any revision of the authoritative copy is readily identifiable as authorized or unauthorized.

(d) Except as otherwise agreed, a person having control of a transferable record is the holder, as defined in s. 671.201(21), of the transferable record and has the same rights and defenses as a holder of an equivalent record or writing under the Uniform Commercial Code, including, if the applicable statutory requirements under s. 673.3021, s. 677.501, or 1s. 679.308 are satisfied, the rights and defenses of a holder in due course, a holder to which a negotiable document of title has been duly negotiated, or a purchaser, respectively. Delivery, possession, and indorsement are not required to obtain or exercise any of the rights under this paragraph.

(e) Except as otherwise agreed, an obligor under a transferable record has the same rights and defenses as an equivalent obligor under equivalent records or writings under the Uniform Commercial Code.

(f) If requested by a person against which enforcement is sought, the person seeking to enforce the transferable record shall provide reasonable proof that the person is in control of the transferable record. Proof may include access to the authoritative copy of the transferable record and related business records sufficient to review the terms of the transferable record and to establish the identity of the person having control of the transferable record.

**(17) CREATION AND RETENTION OF ELECTRONIC RECORDS AND CONVERSION OF WRITTEN RECORDS BY GOVERNMENTAL AGENCIES.--**Each governmental agency shall determine whether, and the extent to which, such agency will create and retain electronic records and convert written records to electronic records.

**(18) ACCEPTANCE AND DISTRIBUTION OF ELECTRONIC RECORDS BY GOVERNMENTAL AGENCIES.--**

(a) Except as otherwise provided in paragraph (12)(f), each governmental agency shall determine whether, and the extent to which, such agency will send and accept electronic records and electronic signatures to and from other persons and otherwise create, generate, communicate, store, process, use, and rely upon electronic records and electronic signatures.

(b) To the extent that a governmental agency uses electronic records and electronic signatures under paragraph (a), the state technology office, in consultation with the governmental agency, giving due consideration to security, may specify:

1. The manner and format in which the electronic records must be created, generated, sent, communicated, received, and stored and the systems established for those purposes.
2. If electronic records must be signed by electronic means, the type of electronic signature required, the manner and format in which the electronic signature must be affixed to the electronic record, and the identity of, or criteria that must be met by, any third party used by a person filing a document to facilitate the process.
3. Control processes and procedures as appropriate to ensure adequate preservation, disposition, integrity, security, confidentiality, and auditability of electronic records.
4. Any other required attributes for electronic records which are specified for corresponding nonelectronic records or reasonably necessary under the circumstances.

(c) Except as otherwise provided in paragraph (12)(f), this section does not require a governmental agency of this state to use or permit the use of electronic records or electronic signatures.

(d) Service charges and fees otherwise established by law applicable to the filing of nonelectronic records shall apply in kind to the filing of electronic records.

(19) INTEROPERABILITY.--The governmental agency which adopts standards pursuant to subsection (18) may encourage and promote consistency and interoperability with similar requirements adopted by other governmental agencies of this and other states and the Federal Government and nongovernmental persons interacting with governmental agencies of this state. If appropriate, those standards may specify differing levels of standards from which governmental agencies of this state may choose in implementing the most appropriate standard for a particular application.

(20) SEVERABILITY.--If any provision of this section or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

### **817.234 False and fraudulent insurance claims.--**

(1)(a) A person commits insurance fraud punishable as provided in subsection (11) if that person, with the intent to injure, defraud, or deceive any insurer:

1. Presents or causes to be presented any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy or a health maintenance organization subscriber or provider contract, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim;

2. Prepares or makes any written or oral statement that is intended to be presented to any insurer in connection with, or in support of, any claim for payment or other benefit pursuant to an insurance policy or a health maintenance organization subscriber or provider contract, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim; or

3a. Knowingly presents, causes to be presented, or prepares or makes with knowledge or belief that it will be presented to any insurer, purported insurer, servicing corporation, insurance broker, or insurance agent, or any employee or agent thereof, any false, incomplete, or misleading information or written or oral statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a health maintenance organization subscriber or provider contract; or

b. Who knowingly conceals information concerning any fact material to such application.

**(b) All claims and application forms shall contain a statement that is approved by the Office of Insurance Regulation of the Financial Services Commission which clearly states in substance the following: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree." This paragraph shall not apply to reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.**

## **RULES**

### **690-125.003 Unfair Discrimination Because of Travel Plans**

(1) No insurer nor person authorized to engage in the business of insurance in the State of Florida shall refuse to issue or refuse to continue any policy, contract or certificate of insurance of any individual, or limit the amount, extent or kind of insurance coverage offered to an individual, an accident, disability or health insurance policy or certificate, because of the intent of the applicant to engage in future lawful foreign travel or based upon past lawful foreign travel, unless the insurer can demonstrate that insureds who have traveled or intend to travel are a separate actuarially supportable class whose risk of loss is different from those insureds who have not traveled and do not intend to travel.

(2) No insurer nor person authorized to engage in the business of insurance in the State of Florida, shall, in determining the rates charged an applicant for coverage under any policy, contract or certificate of life insurance, annuity contract, accident, disability or health insurance, issued or to be issued to be delivered to any resident of this state, consider the intent of the applicant to engage in future lawful foreign travel or past lawful travel of the applicant, unless the insurer can demonstrate that insureds who have traveled or intend to travel are a separate actuarially supportable class whose risk of loss is different from those insureds who have not traveled and do not intend to travel.

(3) No insurer nor person authorized to engage in the business of insurance in the State of Florida shall refuse to issue any policy, contract or certificate of life insurance to or refuse to

continue any policy, contract or certificate of life insurance of any individual or limit the amount, extent or kind of life insurance coverage offered to an individual based solely on the individual's past lawful foreign travel.

(4) No insurer nor person authorized to engage in the business of insurance in the State of Florida shall refuse to issue any policy, contract or certificate of life insurance to or refuse to continue any policy, contract or certificate of life insurance of an individual, or limit the amount, extent or kind of life insurance coverage offered an individual based solely on the individual's future lawful foreign travel plans unless the insurer can demonstrate that individuals who travel are a separate actuarially supportable class whose mortality risk is different from that of individuals who do not travel, and that such risk classification is based on sound actuarial principles and actual or reasonably anticipated experience that correlates to the risk of travel to a specific destination.

(5) An insurer shall file for approval information demonstrating that individuals who travel to a specific destination constitute a separate actuarially supportable class. The insurer shall not utilize such information within any underwriting decision resulting in a refusal to issue, refusal to continue, limitation on amount, extent or kind of life insurance coverage available to an individual until the Office has first approved the filing and determined that the insurer has demonstrated that the underwriting proposed meets compliance with the standards of Section 626.9541(1)(dd), F.S. Nothing in this rule prevents an insurer from asking questions about foreign travel on an application in order to compile information provided such information is not used in any underwriting decision unless the insurer has received prior approval from the Office.

(6) In determining individuals who travel are a separate actuarially supportable class whose risk of loss is different from those individuals who do not travel based on sound actuarial principles and actual or reasonably anticipated experience that correlates to the risk of travel to a specific destination, insurers shall:

(a) Have performed a detailed actuarial analysis detailing the specific impact of the proposed risk;

(b) Demonstrate that all similar risks with similar risk exposure are similarly treated and that the risk is outside of the underwriting parameters that the insurer is accepting for its maximum rated risks;

(c) Use statistically credible data that is specific and relevant to the analysis and risk being evaluated, that is, using a country population death rate is not relevant to the analysis of the risk of short-term travel. In the absence of actual experience, an actuary may submit for the Office's consideration clear actuarial evidence, including clinical experience or expert opinion relied upon by the actuary that demonstrates to the Office that differences in risk are related to the travel;

(d) Disclose the range of underwriting and rating options and how each is supported by the analysis;

(e) Maintain a report prepared by the actuary providing the information used and relied upon by the actuary in preparing his conclusions, including but not limited to: summarizing the source, basis and relevancy of data used, the impact of the risk on expected loss, the range of expected loss within the underwriting class and how the proposed travel risk falls inside or outside of such underwriting range, the analysis performed and the basis of any conclusions reached. Such report shall disclose how compliance with all appropriate actuarial standards of practice is met and specifically detail any standards that are not.

(7) In accordance with Section 626.9541(1)(dd)3., F.S., an insurer may file a petition for a variance or waiver with the Office for a limited exception from the statute and this rule. The petition shall contain supporting information demonstrating that the requested limited exception(s) are based upon national or international emergency conditions that affect the public health, safety, and welfare and are consistent with public policy.

(8)(a) Insurers are required to maintain the following data. The data for each calendar year shall be submitted to the Office annually by January 31 of the following year:

1. The number of applications under which a policy or certificate of life insurance or an annuity contract was denied;
2. The number of applications under which a policy or certificate of life insurance or an annuity contract's continuation was refused; and
3. The number of applications under which a policy or certificate of life insurance or an annuity contract's coverage was limited.

(b) For each specific case, the insurer shall provide the reason for taking such action.

(c) For each case the insurer shall provide a brief summary, prepared by an actuary, of the supporting data and analysis used in taking such action for such specific destination. Such underlying data and analysis shall be available upon request of the Office.

(9)(a) Violation of this rule constitutes unfair discrimination prohibited by Sections 626.9541(1)(g) and (dd), F.S.

(b) An insurer that uses past travel or future lawful travel in underwriting decisions without having first filed and received approval of the Office shall, among other administrative penalties:

1. Provide restitution to all applicants or insureds that were negatively acted upon by the insurer;
2. Issue the coverage applied for which was rejected, subject to the applicants option of the effective date being the date of application or the current date; and
3. Pay any valid claim of an applicant incurred subsequent to the initial application date.

(10) "Travel" shall not include "residency" or relocation for employment. An individual who is absent from the United States for more than one hundred eighty (180) consecutive days and has established a residence in a foreign country during that period is considered to be residing in that country. Residency in a foreign country is not considered "foreign travel" for purposes of this rule.

*Specific Authority 626.9541(1)(dd)3., 626.9611 FS. Law Implemented 626.951, 626.9521, 626.9541(1)(g), (dd) FS. History—New 7-6-06, Amended 11-1-07.*

### **690-142.200 Military Sales Practices**

(1) The purpose of this regulation is to set forth standards to protect active duty service members of the United States Armed Forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair.

(2) Scope – This regulation shall apply only to the solicitation or sale of any life insurance or annuity product by an insurer to an active duty service member of the United States Armed Forces.

(3) Exemptions – This regulation shall not apply to solicitations or sales involving:

- (a) Credit insurance;

(b) Group life insurance or group annuities where there is no in-person, face-to-face solicitation of individuals by an insurance producer or where the contract or certificate does not include a side fund;

(c) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the commissioner; or, when a term conversion privilege is exercised among corporate affiliates;

(d) Individual stand-alone health policies, including disability income policies;

(e) Contracts offered by Servicemembers' Group Life Insurance (henceforth "SGLI") or Veterans' Group Life Insurance (henceforth "VGLI"), as authorized by 38 U.S.C. Section 1965 et seq.;

(f) Life insurance contracts offered through or by a non-profit military association, qualifying under Section 501 (c)(23) of the Internal Revenue Code (IRC), and which are not underwritten by an insurer; or

(g) Contracts used to fund:

1. An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

2. A plan described by Sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the IRC, as amended, if established or maintained by an employer;

3. A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the IRC;

4. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

5. Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

6. Prearranged funeral contracts.

(h) Nothing herein shall be construed to abrogate the ability of nonprofit organizations (and/or other organizations) to educate members of the United States Armed Forces in accordance with Department of Defense DoD Instruction 1344.07 – PERSONAL COMMERCIAL SOLICITATION ON DoD INSTALLATIONS or successor directive.

(i) For purposes of this regulation, general advertisements, direct mail and internet marketing shall not constitute "solicitation." Telephone marketing shall not constitute "solicitation" provided the caller explicitly and conspicuously discloses that the product concerned is life insurance and makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation. Provided however, nothing in this subsection shall be construed to exempt an insurer from this regulation in any in-person, face-to-face meeting established as a result of the "solicitation" exemptions identified in this subsection.



(4) Definitions:

(a) "Active Duty" means full-time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full-time training or in a drill status in the National Guard or United States Armed Forces Reserve.

(b) "Department of Defense (DoD) Personnel" means all active duty service members and all civilian employees, including nonappropriated fund employees and special government employees, of the Department of Defense.

(c) "Door to Door" means a solicitation or sales method whereby an insurance producer proceeds randomly or selectively from household to household without prior specific appointment.

(d) "General Advertisement" means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance, or the promotion of the insurer or the insurance producer.

(e) "Insurer" means an insurance company required to be licensed under the laws of this state to provide life insurance products, including annuities.

(f) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate life insurance, including annuities.

(g) "Known" or "Knowingly" means, depending on its use herein, the insurance producer or insurer had actual awareness, or in the exercise of ordinary care should have known, at the time of the act or practice complained of, that the person solicited is a service member.

(h) "Life Insurance" means insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income and unless otherwise specifically excluded, includes individually issued annuities.

(i) "Military Installation" means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

(j) "MyPay" is a Defense Finance and Accounting Service (DFAS) web-based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.

(k) "Service Member" means any active duty officer (commissioned and warrant) or enlisted member of the United States Armed Forces.

(l) "Side Fund" means a fund or reserve that is part of or otherwise attached to a life insurance policy (excluding individually issued annuities) by rider, endorsement or other mechanism which accumulates premium or deposits with interest or by other means. The term does not include:

1. Accumulated value or cash value or secondary guarantees provided by a universal life policy;
2. Cash values provided by a whole life policy which are subject to standard nonforfeiture law for life insurance; or
3. A premium deposit fund which:
  - a. Contains only premiums paid in advance which accumulate at interest;
  - b. Imposes no penalty for withdrawal;
  - c. Does not permit funding beyond future required premiums;
  - d. Is not marketed or intended as an investment; and
  - e. Does not carry a commission, either paid or calculated.

(m) “Specific Appointment” means a prearranged appointment agreed upon by both parties and definite as to place and time.

(n) “United States Armed Forces” means all components of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

(5) The following acts or practices when committed on a military installation by an insurer with respect to the in-person, face-to-face solicitation of life insurance are declared to be unfair or deceptive acts or practices prohibited by Section 626.9541(1)(a), (b), (d), (e), (g), (k), (l), F.S.:

(a) Knowingly soliciting the purchase of any life insurance product “door to door” or without first establishing a specific appointment for each meeting with the prospective purchaser.

(b) Soliciting service members in a group or “mass” audience or in a “captive” audience where attendance is not voluntary.

(c) Knowingly making appointments with or soliciting service members during their normally scheduled duty hours.

(d) Making appointments with or soliciting service members in barracks, day rooms, unit areas, or transient personnel housing or other areas where the installation commander has prohibited solicitation.

(e) Soliciting the sale of life insurance without first obtaining permission from the installation commander or the commander’s designee.

(f) Posting unauthorized bulletins, notices or advertisements.

(g) Failing to present DD Form 2885, Personal Commercial Solicitation Evaluation, to service members solicited or encouraging service members solicited not to complete or submit a DD Form 2885.

(h) Knowingly accepting an application for life insurance or issuing a policy of life insurance on the life of an enlisted member of the United States Armed Forces without first obtaining for the insurer’s files a completed copy of any required form which confirms that the applicant has received counseling or fulfilled any other similar requirement for the sale of life insurance established by regulations, directives or rules of the DoD or any branch of the Armed Forces.

(i) Using DoD personnel, directly or indirectly, as a representative or agent in any official or business capacity with or without compensation with respect to the solicitation or sale of life insurance to service members.

(j) Using an insurance producer to participate in any United States Armed Forces sponsored education or orientation program.

(6) The following acts or practices by an insurer constitute corrupt practices, improper influences or inducements and are declared to be unfair or deceptive acts or practices prohibited by Section 626.9541(1)(a), (b), (d), (e), (g), (k), (l), F.S., regardless of location:

(a) Submitting, processing or assisting in the submission or processing of any allotment form or similar device used by the United States Armed Forces to direct a service member’s pay to a third party for the purchase of life insurance. The foregoing includes, but is not limited to, using or assisting in using a service member’s “MyPay” account or other similar internet or electronic medium for such purposes. This subsection does not prohibit assisting a service member by providing insurer or premium information necessary to complete any allotment form.

(b) Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship. For purposes of this section, a formal banking relationship is established when the depository institution:

1. Provides the service member a deposit agreement and periodic statements and makes the disclosures required by the Truth in Savings Act, 12 U.S.C. § 4301 et seq. and the regulations promulgated thereunder; and
2. Permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums.
  - (c) Employing any device or method or entering into any agreement whereby funds received from a service member by allotment for the payment of insurance premiums are identified on the service member's Leave and Earnings Statement or equivalent or successor form as "Savings" or "Checking" and where the service member has no formal banking relationship as defined in paragraph (6)(b).
  - (d) Entering into any agreement with a depository institution for the purpose of receiving funds from a service member whereby the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship.
  - (e) Using DoD personnel, directly or indirectly, as a representative or agent in any official or unofficial capacity with or without compensation with respect to the solicitation or sale of life insurance to service members, or to the family members of such personnel.
  - (f) Offering or giving anything of value, directly or indirectly, to DoD personnel to procure their assistance in encouraging, assisting or facilitating the solicitation or sale of life insurance to another service member.
  - (g) Knowingly offering or giving anything of value to a service member for his or her attendance to any event where an application for life insurance is solicited.
  - (h) Advising a service member to change his or her income tax withholding or State of legal residence for the sole purpose of increasing disposable income to purchase life insurance.
  - (i)1. Making any representation, or using any device, title, descriptive name or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, insurance producer or product offered is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, the United States Armed Forces, or any state or federal agency or government entity. Examples of prohibited insurance producer titles include, but are not limited to, "Battalion Insurance Counselor," "Unit Insurance Advisor," "Servicemen's Group Life Insurance Conversion Consultant" or "Veteran's Benefits Counselor."
2. Nothing herein shall be construed to prohibit a person from using a professional designation awarded after the successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning. Such designations include, but are not limited to, Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Certified Financial Planner (CFP), Master of Science In Financial Services (MSFS), or Masters of Science Financial Planning (MS).
  - (j) Soliciting the purchase of any life insurance product through the use of or in conjunction with any third party organization that promotes the welfare of or assists members of the United States Armed Forces in a manner that has the tendency or capacity to confuse or mislead a service member into believing that either the insurer, insurance producer or insurance product is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, or the United States Armed Forces.

- (k) Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid.
- (l) Excluding individually issued annuities, misrepresenting the mortality costs of a life insurance product, including stating or implying that the product “costs nothing” or is “free.”
- (m) Making any representation regarding the availability, suitability, amount, cost, exclusions or limitations to coverage provided to a service member or dependents by SGLI or VGLI, which is false, misleading or deceptive.
- (n) Making any representation regarding conversion requirements, including the costs of coverage, or exclusions or limitations to coverage of SGLI or VGLI to private insurers which is false, misleading or deceptive.
- (o) Suggesting, recommending or encouraging a service member to cancel or terminate his or her SGLI policy or issuing a life insurance policy which replaces an existing SGLI policy unless the replacement shall take effect upon or after the service member’s separation from the United States Armed Forces.
- (p) Deploying, using or contracting for any lead generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer, if that is the case, for the purpose of soliciting the purchase of life insurance.
- (q) Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person, face-to-face meeting with a prospective purchaser.
- (r) Excluding individually issued annuities, failing to clearly and conspicuously disclose the fact that the product being sold is life insurance.
- (s) Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by Section 10 of the “Military Personnel Financial Services Protection Act,” Pub. L. No. 109-290, p.16.
- (t) Excluding individually issued annuities, when the sale is conducted in-person face-to-face with an individual known to be a service member, failing to provide the applicant at the time the application is taken:
  1. An explanation of any free look period with instructions on how to cancel if a policy is issued; and
  2. Either a copy of the application or a written disclosure. The copy of the application or the written disclosure shall clearly and concisely set out the type of life insurance, the death benefit applied for and its expected first year cost. A basic illustration that meets the requirements of Section 626.99, F.S., shall be deemed sufficient to meet this requirement for a written disclosure.
- (u) Excluding individually issued annuities, recommending the purchase of any life insurance product which includes a side fund to a service member unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable.
- (v) Offering for sale or selling a life insurance product which includes a side fund to a service member who is currently enrolled in SGLI, is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant’s SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant’s insurable needs for life insurance.

1. “Insurable needs” are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant’s estate and/or survivors or dependents.

2. “Other military survivor benefits” include, but are not limited to: the Death Gratuity, Funeral Reimbursement, Transition Assistance, Survivor and Dependents’ Educational Assistance, Dependency and Indemnity Compensation, TRICARE Healthcare benefits, Survivor Housing Benefits and Allowances, Federal Income Tax Forgiveness, and Social Security Survivor Benefits.

(w) Excluding individually issued annuities, offering for sale or selling any life insurance contract which includes a side fund:

1. Unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;

2. Unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined product. For this disclosure, the effective rate of return will consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule will be provided for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and

3. Which by default diverts or transfers funds accumulated in the side fund to pay, reduce or offset any premiums due.

(x) Excluding individually issued annuities, offering for sale or selling any life insurance contract which after considering all policy benefits, including but not limited to endowment, return of premium or persistency, does not comply with standard nonforfeiture law for life insurance.

(y) Selling any life insurance product to an individual known to be a service member that excludes coverage if the insured’s death is related to war, declared or undeclared, or any act related to military service except for an accidental death coverage, e.g., double indemnity, which may be excluded.

*Specific Authority 626.307(1), 626.9611(1), (2) FS. Law Implemented 626.307(1), 626.951, 626.9521, 626.9541(1), 626.9611(2) FS. History–New 11-1-07.*

### **690-149.021 Form Filing Procedures**

(1)(a)1. All filings shall be made in accordance with paragraph (b) below.

2.a. For purposes of the rules in this part and the time periods in Section 627.410, F.S., a filing is considered “filed” with the Office upon the receipt of the material required by paragraph (b), on business days between the hours of 8:00 a.m. and 5:00 p.m. eastern time. Filings received after 5:00 p.m. shall be considered to be received the following business day.

b. For purposes of the rules in this part, the term “filed” does not mean “approved.” The term “filed” refers to the date on which the filing is filed with the Office and is the date on which the approval process of Section 627.410, F.S., commences.

(b) A form filing shall consist of the following items:

1.a. A brief transmittal letter explaining the type and nature of the filing, including the subject,

the purpose, and any unusual features relative to products being sold by other companies. The letter shall also indicate if the filing is new or is a resubmission.

b. If the filing is a resubmission, the letter shall indicate the Florida filing number of the prior filing.

c. If the filing is either a group life or a group annuity form, the letter shall indicate the Florida Statute number under which the form is to be issued.

2. Form OIR-B2-1507, "Office of Insurance Regulation Life and Health Forms and Rates Universal Standardized Data Letter" as adopted in Rule 69O-149.022, F.A.C., completely filled out in accordance with Form OIR-B2-1507A, "Office of Insurance Regulation Life and Health Forms and Rates Universal Standardized Data Letter Instruction Sheet" as adopted in Rule 69O-149.022, F.A.C.

3. The checklist appropriate for the type of form being filed and any information required by that checklist. All forms and checklists are listed and adopted in Rule 69O-149.022, F.A.C.

4. Any certifications of rates, cost indices, or other items, if required by the appropriate checklist or by rule.

5. The form(s) being filed. Each form shall include the name of the company, and have an identifying form number in the lower left hand corner of the first page of the form.

6. Each filing shall contain an actuarial memorandum, certified and signed by a qualified actuary. The actuarial memorandum for life and annuity product filings shall demonstrate compliance with the Standard Valuation Law (Section 625.121, F.S.). In addition, filings for life insurance products other than annuities shall demonstrate compliance with the Standard Nonforfeiture Law (Section 627.476, F.S.).

(2) Each filing shall contain forms for only one type of coverage, i.e., ordinary life, variable life, major medical, etc. However, a filing may contain more than one form if the forms are for the same type of coverage.

(3) Each filing shall contain forms for only one company.

(4) Combination forms, products that contain both life and health coverages, shall be submitted separately but simultaneously and shall be clearly marked to indicate that they are combination filings, one as life and one as health.

(5) Complete filings shall be submitted electronically to <https://iportal.fldfs.com>.

(6)(a) Every insurer submitting a form filing shall be notified as to whether the filing has been affirmatively approved by the Office, or has been disapproved by the Office within any statutory review period of the date of receipt of the filing.

(b) Submissions that do not include the required material to meet the definition of a filing, or that include material that is illegible, shall not be accepted and shall be returned as incomplete without processing.

(c) Every insurer submitting a form filing for which the Office determines that additional information is necessary for a proper review will be notified of the additional information within the statutory limit. Every insurer shall submit the required data by a date certain stated in the clarification letter to allow the Office sufficient time to perform a proper review. Failure to correct the filing by the date certain in the clarification letter will result in an affirmative disapproval of the filing by the Office.

(7) Definitions. As used in this rule:

(a) New Filing – A new filing is one that is being submitted for the first time. This includes submission of revisions to a previously approved form.

(b) Resubmission – A filing submission in response to a final disapproval from the Office is a resubmission. It is given a new filing number by the Office. This term does not apply to ongoing correspondence under the same filing number before an affirmative approval or disapproval by the Office.

*Specific Authority 624.308, 624.424(1)(c) FS. Law Implemented 624.307, 625.121, 627.410, 627.476, 627.807 FS. History–New 10-29-91, Amended 8-23-93, 4-18-94, 8-22-95, 5-15-96, 4-4-02, 6-19-03, Formerly 4-149.021, Amended 5-18-04.*

### **69O-149.023 Review**

(1) Filings will be reviewed for compliance with applicable statutes and rules as stated on the forms adopted in Rule 69O-149.022, F.A.C., and will be disapproved for failure to comply. Filings will be disapproved for inconsistencies or ambiguities which are misleading.

(2) The policy may not reserve the right to change contractual provisions without the written consent of the policyholder unless the nature and parameters of such changes are clearly expressed in the contract.

(3) A group life or annuity policy may not reserve the right to change contractual provisions which will adversely affect the annuitization benefit for a certificateholder which is attributable to premiums or contributions already made to the contract.

(4) The insurer shall submit a description of distribution systems (e.g. direct marketing, marketing through agents, marketing through financial or other institutions, etc.), and the intended target population for all product filings.

*Specific Authority 624.308, 627.805, 626.9611 FS. Law Implemented 624.307, 625.121, 626.9541, 626.9641, 626.99, 627.410, 627.411, 627.474, 627.476 FS. History–New 5-15-96, Formerly 4-149.023, Amended 5-18-04.*

### **69O-154.106 Minimum Standards for Benefits.**

An individual policy of accident and health insurance or nonprofit, medical, surgical, or hospital service corporation contract shall not be delivered or issued for delivery in this state unless the outline of coverage required by Section 627.642, Florida Statutes, labels and describes the policy or contract in accordance with the specified categories of coverage contained in this rule. Nothing in this rule shall preclude the issuance of any policy or contract combining two or more categories of coverage set forth in Section 627.643(2), Florida Statutes. This rule does not apply to policies issued pursuant to a conversion privilege. Types of policies controlled by this rule are as follows:

(1) Basic Hospital Expense Insurance – “Basic Hospital Expense Insurance” is a policy of accident and health insurance which provides coverage for a period of not less than 31 days during any one period of confinement for each person insured under the policy for the expense incurred for necessary treatment and services rendered as a result of an injury or sickness for at least the following:

(a) Daily hospital room and board in an amount not less than the lesser of the average semi-private room rate in the community in which the insured resides or \$30.00 per day; and

(b) Miscellaneous hospital service in an amount not less than ten times the daily hospital room and board benefit for the expense incurred for the charges made by the hospital for services and supplies rendered by the hospital and provided for use only during the period of confinement; and

(c) Hospital outpatient services up to an amount of \$50.00 for hospital-rendered services as an outpatient incurred within 72 hours of any one accident. Benefits provided under paragraphs (a) and (b) above may be provided subject to a combined deductible amount in excess of \$100.00. This section does not prohibit a policy or rider especially designed to provide benefits for an insured person to supplement existing in force coverage.

(2) Basic Medical Expense Insurance – “Basic Medical Expense Insurance” is a policy of accident and health insurance which provides coverage for each person insured under the policy for the expense incurred for the necessary services and treatment of an injury or sickness for at least the following: In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than \$5.00 per call, one call per day, for at least 21 such calls during “one period of confinement” or similar benefit acceptable to the Department.

(3) Basic Surgical Expense Insurance – “Basic Surgical Expense Insurance” is a policy of accident and health insurance which provides coverage for each insured under the policy for the expense incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(a) Surgical procedures for the treatment of a sickness, or injury, and endoscopic procedures including any preoperative and postoperative care usually rendered in connection with such operation or procedure, in an amount (a) not less than 75% of the reasonable charges or (b) if specified in dollar amounts, a fee schedule providing amounts for any procedure at least equal to those provided in a fee schedule with a maximum of \$400.00 based on a relative value schedule acceptable to the Commissioner of Insurance.

(b) Anesthetic services, consisting of administration of necessary general anesthetics and related procedures in connection with covered surgical service rendered by a physician other than the physician (or his assistant) performing the surgical services, of at least 15 percent of the surgical service benefit provided. Surgical schedules contained in the policy shall include a provision providing coverage for procedures not specifically listed in the schedules and not otherwise excluded by the policy, and benefits therefore shall be consistent with the benefits for comparable procedures. Whenever a policy is written that provides at least the coverages required for both basic hospital expense coverage and basic medical and/or basic surgical expense coverages, the allowable deductible may be applied to the combined coverage.

(4) Hospital Confinement Indemnity Insurance – “Hospital Confinement Indemnity Insurance” is a policy of accident and health insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than \$10.00 per day and not less than 31 days during any one period of confinement for each person insured under the policy and with no elimination period unless benefit period is 365 days or more, in which case, a three day elimination period will be acceptable.

(5) Major Medical Expense Insurance –

(a) “Major Medical Expense Insurance” is a policy of accident and health insurance which provides hospital, medical and surgical coverage as follows:



1. The aggregate maximum is not less than \$10,000 per covered person.
  2. The co-payment by a covered person is not more than 25 percent of covered charges except that the co-payment percentage applicable to subparagraph (5)(b)7. of this section may not be more than 50 percent.
  3. The deductible is stated on a per person, per family, per illness, per benefit period or per year basis, or a combination of such basis, and, other than as specified in the next sentence, is not more than 10 percent of the maximum limit under the coverage. In lieu of a fixed dollar amount, the deductible amount may be expressed as (a) the higher of a fixed dollar amount of basic deductible and the policy's covered charges paid by other medical expense coverage; or (b) not more than \$500 plus the policy's covered charges paid by other medical expense coverage.
  4. The maximum benefit period of an "each cause" type of policy (where a separate deductible is required for different sicknesses and accidents) is not less than 18 months and the maximum benefit period for an "all cause" type of policy (where separate deductibles are not required for different sicknesses or accidents) is not less than the number of days remaining in the calendar or policy year after the deductible has been met.
  5. The period allowed to satisfy the deductible is not less than 90 days.
- (b) Major Medical Expense Insurance must provide for each covered person coverage of:
1. Hospital room and board expenses, prior to application of the co-payment percentage, for not less than \$40.00 daily (or in lieu thereof the average daily cost of semiprivate room rate in the area where the insured resides) for a period of not less than 30 days for any period of continuous hospital confinement;
  2. Miscellaneous hospital services, prior to application of the co-payment percentage, for an aggregate maximum of not less than \$1,500 or 15 times the daily room and board rate if specified in dollar amounts;
  3. Surgical fees, prior to application of the co-payment percentage, to a maximum of not less than \$600.00 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;
  4. Anesthetic services, prior to application of the co-payment percentage of at least 15 percent of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthetic services at the same unit value as used for the surgical schedule;
  5. Doctor visits, in or out of the hospital, with minimum dollar amounts per visit, prior to application of the co-payment percentage, equal to not less than \$8.00 per visit, covering not less than one visit per day and for an aggregate maximum of such covered charges of not less than \$600.00;
  6. Out-of-hospital diagnostic x-rays and tests, prior to application of the co-payment percentage, for an aggregate maximum of such covered charges of not less than \$600.00;
  7. No fewer than three of the following additional benefits, prior to application of the co-payment percentage, for an aggregate maximum of such covered charges of not less than \$1,000:
    - a. Private duty registered or if not available, licensed practical nurse services performed by other than a family member while insured is hospital confined;
    - b. Convalescent nursing home care;
    - c. Diagnosis and treatment by a radiologist or physiotherapist;
    - d. Rental of special medical equipment, as defined by the insurer in the policy;
    - e. Artificial limbs or eyes, casts, splints, trusses or braces;

f. Treatment for functional nervous disorders, and mental and emotional disorders;

g. Out-of-hospital prescription drugs and medications.

(6) Disability Income Protection Insurance –

(a) “Disability Income Protection Insurance” is a policy of health insurance identified in the outline of coverage, as to scope of coverage, if limited (e.g., accident only or sickness only), which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from sickness or injury or a combination thereof.

(b) Such coverage shall not require a loss from accidental injury to commence within less than 30 days after the date of an accident.

(c) No reduction in benefits shall be put into effect because of an increase in Social Security disability benefits during a benefit period.

(7) Accident Only Insurance –

(a) “Accident Only Insurance” is a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident.

(b) Accidental death and dismemberment benefits shall be payable if the loss occurs within a period of time of not less than 90 days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of the accident.

(c) The amount of the accidental death benefit shall not be less than \$1,000.00.

(d) The amount of the dismemberment benefit shall not be less than:

1. \$500.00 in the case of a single dismemberment, and
2. \$1,000.00 in the case of a double dismemberment.

(e) Specified dismemberment benefits shall not be in lieu of other benefits unless the specific benefit exceeds the other benefit.

(8) Limited Benefit Insurance – “Limited Benefit Insurance” is that form of policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases), specifically named accident, or specifically named limited market fulfilling an experimental or reasonable need.

(a) “Specified Disease Insurance” is a policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not in excess of \$250.00 and an overall aggregate benefit limit of not less than \$2,500.00 and a benefit period of not less than 2 years.

(b) “Specified Accident Coverage” is a policy which provides coverage for specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount of not less than \$1,000 for accidental death; \$1,000 for double dismemberment and \$500 for single dismemberment.

(9) Supplemental Insurance – Any policy or contract which provides benefits that are less than the minimum standards for benefits required under subsections (1) through (3) of Rule 69O-154.106, F.A.C., may be delivered or issued for delivery if the outline of coverage describes such policy or contract as “supplemental hospital expense insurance”, “supplemental medical expense insurance” or “supplemental surgical expense insurance” and prominently states that it does not meet the requirements of minimum standards for the category involved.

(10) Non-Conventional Coverage – Nothing contained in this section shall prohibit the issuance of a policy or contract that does not fall within subsections (1) through (9) of Rule 69O-154.106,

F.A.C., if such policy or contract is either experimental in nature or is demonstrated to be a type coverage that will fulfill a reasonable need of a person or persons to be insured and is appropriately and prominently described in the outline of coverage.

(11) Home Service Health Coverage (Exemption) –

(a) “Home Service Health Coverage” is a policy sold by a combination debit company and shall be exempt from the minimum benefit requirements contained in Rule 69O-154.106, F.A.C.

(b) In order for a company to qualify as a combination debit company under this Rule, it must certify that at least 90 percent of its Florida premium income for individual health insurance arises from business produced by home service debit agents. If a combination company does not meet this requirement on an overall basis, but does meet it relative to a combination department, it may qualify under this Rule relative only to that combination department; in this case, however, the applicable policy forms may be approved for use only by such combination department.

(c) Such certification as mentioned above must be included in the letter of transmittal of each policy submitted.

*Specific Authority 627.643, 624.308, 627.9407(1) FS. Law Implemented 624.307(1), 627.642, 627.643, 627.9404(1) FS. History–New 1-1-75, Formerly 4-37.06, Amended 5-17-89, 9-18-89, Formerly 4-37.006, Amended 3-24-99, Formerly 4-154.106.*

## **MISCELLANEOUS**

### **Certification Regarding Compliance with 627.5515(5)**

I, \_\_\_[name of company officer], do hereby truthfully certify to the Florida Office of Insurance Regulation, regarding form number(s) \_\_\_[insert each and every form number being certified – do not use “et al” or “etc”], that prior to solicitation in Florida of any coverage utilizing said forms, said forms were reviewed and approved by the insurance department in the state in which the group policy was issued, which was the state of \_\_\_[insert name of state].

Date: \_\_\_[insert date of certification]

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Signature of Company Officer  
[insert typed name of Company Officer]  
[insert name of Insurance Company]

## **New Florida Life & Health Legislation**

**HB 947 – Long-Term Care Coverage:** Chapter Law #2006-254, Laws of Florida; Effective June 20, 2006; by Representative Legg.

This legislation directs the Agency for Health Care Administration to establish a qualified state Long-Term Care Insurance Partnership Program in Florida, in consultation with the Office of Insurance Regulation and the Department of Children and Family Services. In addition to providing certain program requirements, the bill also provides that, for purposes of determining Medicaid eligibility, assets in an amount equal to the insurance benefit payments made to, or on behalf of, an individual who is a beneficiary under a qualified state Long-Term Care Insurance Partnership Program in Florida shall be disregarded. Essentially, this enables Floridians to qualify for coverage of the substantial costs associated with provision of long-term care services under Medicaid without first being required to substantially exhaust – or “spend down” – assets and resources.

The bill also requires the Office of Program Policy Analysis and Government Accountability to prepare a report on the implementation of a qualified state Long-Term Care Insurance Partnership Program in Florida. The bill also amends several laws governing long-term care insurance as follows:

- provides that a long-term care policy is incontestable after being in force for 2 years, except in instances of non-payment of premium;
- prohibits an insurer from imposing a new waiting period when a policy is replaced through an affiliated insurer;
- eliminates the current minimum nursing home benefit of 24 months of coverage;
- requires that any long-term care insurance policy or certificate issued or renewed, at the policyholder’s option, shall make available to the insured the contingent benefit upon lapse as provided in the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners;
- prohibits existing policyholders from being charged premiums that exceed the premiums the insurer is charging to new policyholders; and
- requires insurers to pool the claims experience of all affiliated carriers when calculating rates rather than only the policy forms providing similar benefits of the insured.

**HB 299 – Travel-Limited Life Insurance:** Chapter Law #2006-277, Laws of Florida; Effective July 1, 2006; by Representative Sobel.

The bill is cited as the “Freedom to Travel Act.” The legislation creates a new unfair or deceptive trade practice provision under the Insurance Code (s. 626.9541, F.S.) which would prohibit life insurers from refusing coverage or otherwise discriminating against an individual solely on the basis of that individual’s past lawful foreign travel experiences. The bill further prohibits life insurers from refusing coverage or otherwise discriminating against an individual solely on the

basis of that individual's future lawful foreign travel plans, unless life insurers demonstrate, and the Office of Insurance Regulation determines, that:

- individuals who intend to travel are a separate actuarially supportable class whose risk of loss is different from those individuals who do not intend to travel; and
- such risk classification is based on sound actuarial principles and actual or reasonably anticipated experience that correlates to the risk of travel to a specific destination.

**SB 590 — Health Maintenance Contracts: Chapter 2007-215,  
L.O.F.; Effective July 1, 2007; by Health Regulation; and  
Senators Saunders, Atwater, and Lynn.**

This bill amends subsection (25) of s. 641.31, F.S., to expand the right of a subscriber covered under a HMO contract who is a resident of a continuing care facility or a retirement facility, to be referred to that facility's skilled nursing unit or assisted living facility. The bill deletes the current requirement that the HMO primary care physician make a determination that such care is in the best interests of the subscriber. Instead, the bill requires that such referral be requested by the subscriber and agreed to by the facility, if the primary care physician finds that such care is medically necessary. The bill retains the requirements that the facility agree to be reimbursed at the HMOs contract rate negotiated with similar providers for the same services and supplies; and that the facility meet all guidelines established by the HMO related to quality of care, utilization, referral authorization, risk assumption, use of the HMOs network, and other criteria applicable to providers under contract for the same services and supplies. The bill further requires that HMOs provide in writing a disclosure of such rights to new subscribers who reside at a continuing care facility or retirement facility, including the right to use a specified grievance process in the event their request to be referred to the skilled nursing unit or assisted living facility at their place of residence is not honored.



**INFORMATIONAL MEMORANDUM**  
**DFS-10-2007**  
**ISSUED August 28, 2007**  
Department of Financial Services  
**Alex Sink, CFO**

**Training Requirements for Insurance Agents Selling, Soliciting or Negotiating  
Long-Term Care Insurance**

The purpose of this memorandum is to notify all health insurance agents who sell, solicit or negotiate long-term care insurance of a new agent training requirement.

All such agents must complete eight hours of initial long-term care insurance training on or before December 31, 2007, and must complete four hours of additional training each 24-month period thereafter. Appointing insurers bear the responsibility of confirming that this training requirement has been met by their agents.

The Office of Insurance Regulation has adopted Rule 69O-157.201, F.A.C., which sets forth the complete requirements for a qualifying Long-Term Care Partnership Program policy. All health insurers are required to make certain that their appointed agents have acquired the training necessary and sufficient to fully understand the provisions of these partnership policies.

Agents can contact their appointing insurers to learn what courses may be offered by them to meet this training requirement. Long-term care insurance training may also be available as a continuing education course. Agents can access courses that are available as continuing education credit courses on the Department's website at [www.myfloridacfo.com](http://www.myfloridacfo.com). (Click on **Licensing and Renewal**, then under **Links for Agents & Adjusters** click on **Find an Education Course**. Scroll down to the bottom of the page and click on **Perform an Advance Search**. In the **Search for Special Courses** drop down box, select **Long-Term Care Partnership**).

Continuing education providers may request that the Department review any currently approved long-term health care course to determine whether the course meets the agent training requirements of the National Association of Insurance Commissioners. The recommended course outline can be found on our web site at [www.MyFloridaCFO.com/agents/Memos/LongTermCare.htm](http://www.MyFloridaCFO.com/agents/Memos/LongTermCare.htm).

If you have questions about this agent training requirement, or how a health care course can be qualified for long-term care training requirements or continuing education requirements, please contact the Bureau of Licensing at (850) 413-3137.

If you have questions about Rule 69O-157.201, F.A.C., please contact Robin Hall, Office of Insurance Regulation, at (850) 413-5198 or [Robin.Hall@fldfs.com](mailto:Robin.Hall@fldfs.com).



**INFORMATIONAL MEMORANDUM**  
**OIR-07-11M**  
**ISSUED**  
**July 30, 2007**  
Office of Insurance Regulation  
**Kevin M. McCarty**  
Commissioner

**\*REVISED\***

**All Life and Health Insurers**

**Long-Term Care Insurance**

**Adoption of amendments to Chapter 690-157, Florida Administrative Code**

The purpose of this memorandum is to notify Florida Life and Health insurers of changes to Chapter 690-157, Part II, Florida Administrative Code, and of the creation of Part III, Long-Term Care Insurance Partnership Plans.

Effective August 1, 2007, the following applies to new and existing Long-Term Care Insurance policies under the new Long-Term Care Partnership Program:

1. An insurer may offer policyholders or certificate holders (hereafter "policyholders") the option of exchanging an existing Long-Term Care contract for a new Long-Term Care contract.
2. An insurer must provide necessary and sufficient training for its producers in understanding Long-Term Care Partnership policies prior to any solicitations, sales or negotiations, and maintain records of such training.
3. Establishes standards for approved Long-Term Care Partnership Program policies and certificates (hereafter "policies") with an effective date of on or after January 1, 2007.
  - Requires that Partnership policy forms and rates be filed and approved;
  - Requires that the policy be a qualified long-term care insurance policy under the provisions of Section 627.9404(12), F.S.;
  - Establishes eligibility for reciprocal agreements for policies purchased outside of Florida;
  - Establishes standards for inflation protection;

- Requires insurers to provide a disclosure notice. The insurer may use Form OIR-B2-1786 (1/2007) adopted and incorporated by reference. If language is modified, the notice shall be filed for approval with the Office of Insurance Regulation;
- Requires insurers to notify policyholders, in writing, when an action will result in the loss of Partnership status, how this action will impact their policy and advise how to retain Partnership status, if possible;
- Requires that any insurer issuing or marketing policies that qualify as Partnership policies notify all of its policyholders with existing Long-Term Care coverage issued on or after March 1, 2003, of the benefits associated with a Partnership policy and offer the optional exchange, along with required disclosures;
- Defines inflation coverage limitations;
- Establishes insurer reporting requirements to the Health and Human Services Secretary
- Establishes requirement that insurers provide to any insured requesting such information a copy of Form OIR-B2-1781 (12/06), Approved Long-Term Care Partnership Program Policy Summary.

This notice is not intended to be a comprehensive analysis of the rule. You are responsible for reading the rule and taking any necessary steps to be in compliance. The full text of Chapter 690-157, Florida Administrative Code, can be found at: <http://www.flrules.org> .

If you have any questions about changes in Rule 690-157, please contact Robin Hall, Office of Insurance Regulation, at (850) 413-5198 or [Robin.Hall@fldfs.com](mailto:Robin.Hall@fldfs.com) . If you have questions on producers training, please contact the Bureau of Licensing at (850) 413-3137. A copy of the Producer Training Requirement Outline can be found at: <http://www.fldfs.com/Agents/Memos/DFS-10-2007-07-20-07.pdf> For questions on Medicaid Eligibility and Asset Disregard, please contact the ACCESS Call Center at (866) 762-2237 and for questions regarding the State Plan Amendment, please contact Susan Rinaldi, Agency for Healthcare Administration, at (850) 487-3028 or [rinaldis@ahca.myflorida.com](mailto:rinaldis@ahca.myflorida.com) .





**OFFICE OF INSURANCE REGULATION**  
***Life & Health Product Review***

**APPROVED LONG TERM CARE PARTNERSHIP PROGRAM POLICY SUMMARY**

1. Name of insured \_\_\_\_\_
2. Policy/certificate number \_\_\_\_\_
3. Effective date of coverage \_\_\_\_\_
4. The policy/certificate was issued in the state of \_\_\_\_\_
5. Issue age of the insured at the time the coverage was issued \_\_\_\_\_
6. The policy/certificate was issued  With  Without inflation coverage
7. The inflation coverage is  Simple Inflation  Compound Inflation  None
8. The inflation coverage is currently in effect on the coverage  Yes  No  
if no, the date inflation coverage ceased \_\_\_\_\_
9. The policy is intended to meet the standards of a tax qualified long-term care policy  Yes  No
10. The cumulative dollar amount of insurance benefits paid \$\_\_\_\_\_ (Note: The indicated amount does not include any payments for cash surrender, return of premium death benefits, or waiver of premium, and if joint coverage, the amount is for the indicated insured only)
11. The total dollar amount of insurance benefits remaining available under the policy \$\_\_\_\_\_
12. As of date for which this form was completed \_\_\_\_\_
13. The name, phone number and email address of the person completing this form

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address

I hereby certify that the above information is true and accurate and that the coverage meets partnership status in Florida at the time of this certification.

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_

## Partnership Status Disclosure Notice

### Important Information Regarding Your [Policy's] [Certificate's] Long-Term Care Insurance Partnership Status

This disclosure notice is issued in conjunction with your long-term care policy:

Insured name: \_\_\_\_\_  
Policy number: \_\_\_\_\_  
Date of issue: \_\_\_\_\_

Some long-term care insurance policies [certificates] sold in Florida qualify for the Florida Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meet certain State and Federal requirements. Long-term care insurance policies [certificates] that qualify as Partnership Policies [Certificates] may be entitled to special treatment, and in particular an "Asset Disregard," under Florida's Medicaid program.

**Asset Disregard** means that an amount of the policyholder's [certificateholder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy [Certificates] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds \$[500,000]. Asset Disregard is **not** available under a long-term care insurance policy [certificate] that is not a Partnership Policy [Certificate]

**Partnership Policy [Certificate] Status.** Your long-term care insurance policy [certificate] is intended to qualify as a Partnership Policy [Certificate] under the Florida Long-Term Care Partnership Program as of your Policy's [Certificate's] effective date.

**What Could Disqualify Your [Policy] [Certificate] as a Partnership Policy.** If you make any changes to your [policy] [certificate], such changes could affect whether your [policy] [certificate] continues to be a Partnership Policy. ***Before you make any changes, you should consult with [insert name of carrier] to determine the effect of a proposed change.*** In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your [policy] [certificate] as a Partnership Policy [Certificate], you would not receive beneficial treatment of your [policy] [certificate] under the Medicaid program of that State. The information contained in this Notice is based on current State and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your [policy] [certificate] under Florida's Medicaid program.

**Additional Information.** If you have questions regarding your insurance policy [certificate] please contact [insert name of carrier.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Florida Department of Children and Families.



**INFORMATIONAL MEMORANDUM**  
**OIR-07-009M**  
**ISSUED**  
**July 9, 2007**  
Office of Insurance Regulation  
**Kevin M. McCarty**  
Commissioner

**NOTICE OF NEW LEGISLATION**

**Health Maintenance Contracts**

*This notice presents a summary of certain legislative changes enacted in the 2007 Regular Session of the Florida Legislature. This notice is not intended to be a comprehensive analysis of bills that may be of interest or importance to your company. Some legislation may require action on the part of the companies or licensees to ensure compliance. You are encouraged to review specific bills, found by legislative bill number at <http://www.leg.state.fl.us>*

Senate Bill 590

Section 1 – Health maintenance contracts

Effective Date: July 1, 2007

Amends s. 641.31(25), F.S. requiring health maintenance organizations to provide in writing a disclosure to new subscribers who reside at a continuing care facility or a retirement facility consisting of a nursing home or assisted living facility of their right to request a referral to that facility's skilled nursing unit or assisted living facility.

Pursuant to s. 641.31(1), F.S., contracts must be amended and filed with the Florida Office of Insurance Regulation to include such notices in the subscriber contract.

This legislation took effect July 1, 2007. Chapter No. 2007-215, Laws of Florida.

If you have any questions regarding the filing process, please contact Tracie Lambright, Life and Health Product Review, Florida Office of Insurance Regulation at [Tracie.Lambright@fldfs.com](mailto:Tracie.Lambright@fldfs.com) or at (850) 413-3152.



## **INFORMATIONAL MEMORANDUM**

**OIR-06-13M**

**ISSUED**

**July 6, 2006**

Office of Insurance Regulation

**Kevin M. McCarty**

Commissioner

### **All Life & Health Insurers**

#### **Freedom to Travel Act**

The purpose of this Memorandum is to notify Florida life and health insurers of changes to Part IX, Chapter 626, Unfair Insurance Trade Practices, of the Florida Insurance Code. The Freedom to Travel Act, effective date July 1, 2006, a copy of which is attached, adds paragraph (dd) to subsection (1) of Section 626.9541, Florida Statutes, and expands the protections against discrimination in regard to the underwriting of life insurance based on past lawful foreign travel experiences or future lawful foreign travel plans, with certain exceptions.

Rule 690-125.003, Florida Administrative Code, referred to as the Unfair Discrimination Because of Travel Plans, became effective on July 6, 2006, a copy is attached. Pursuant to this rule, an insurer may not refuse to issue or continue, or determine a rate for, any policy, contract or certificate of life insurance, annuity contract, accident, disability or health insurance, based solely on the intent of the applicant to engage in future lawful foreign travel or based upon past lawful foreign travel, unless the insurer can demonstrate that insureds who have traveled or who intend to travel are a separate actuarially supportable class whose loss of risk is different from those who have not traveled and do not intend to travel.

This notice is not intended to be a comprehensive analysis of the bill or the rule. You are responsible for reading both documents and taking any necessary steps to be in compliance. If you have questions about the requirements, please contact Monica Rutkowski, Director, Life & Health Product Review, at 850-413-5110.



**INFORMATIONAL MEMORANDUM**  
**OIR-06-05M**  
**ISSUED**  
**April 13, 2006**  
Office of Insurance Regulation  
**Kevin M. McCarty**  
Commissioner

**NOTICE TO ALL INSURERS DOING BUSINESS IN FLORIDA**  
**USE OF FORMS IN SPANISH LANGUAGE**

The purpose of this Memorandum is to advise insurers doing business in Florida of the opportunity to use policy forms in the Spanish language.

Florida's population is growing at record rates and the Hispanic component of that growth is significant. Spanish is spoken in 35% of the homes in Florida and recent figures estimate the state's Hispanic population at over 3.3 million (Source: The University of Florida, Bureau of Economic and Business Research).

To better serve your customers, you may wish to use policy forms written in Spanish. The Office of Insurance Regulation (Office) encourages this practice in order to provide a clear understanding of the policy form for Spanish speaking policyholders. The Office will soon add to its website a listing of carriers and the types of Spanish policies offered.

To assist the Office in populating this list, carriers that already offer Spanish forms approved by the Office are requested to provide the following information and submit to **forms\_survey@fldfs.com** so we may include your information on our website:

1. Insurer name;
2. List of policy forms offered in Spanish by type, i.e., life, major medical, auto, homeowners, etc.; and
3. Include the Office of Insurance Regulation file number under which the forms were approved.

If your company wishes to use your policy forms in Spanish, please contact the following persons within the Office:

For Life and Health companies, please contact Amber Graham at (850) 413-5136.

For Property and Casualty companies, please contact Brian Bogner at (850) 413-5266.

# FLORIDA OFFICE OF INSURANCE REGULATIONS

## Cover Letter 690-149.021(b), F.A.C.

Policy Form #: \_\_\_\_\_

### 1. Type of Filing/Coverage:

- Provide a description of the type of filing, state the title of the submitted form(s) and explain any feature(s) or benefit(s).
- State whether the filing is new or a resubmission? State applicable approval date(s) and Florida file number(s), (e.g., FLH 01-12345). If this is a resubmission please provide an explanation of why the original filing was not approved and provide a copy of all the related correspondence of the original submission.
- State whether these forms replace any previously approved forms? If so, clearly identify the forms that are to be replaced and explain all revisions/updates.
- State whether these forms will be used with any other forms? Provide a list of all forms to be used with submitted form(s). Include the dates of approval and the Florida file number(s), (e.g., FLH 01-12345).

### 2. Target population:

- List the type of individual or group to be solicited. If marketing Groups, list all groups to be marketed by statutory requirements.
- Provide target age limit and give details of age cancellation requirements.

### 3. Marketing Methods / Distribution:

- How will this form be used or sold? Provide details of distribution processes.
- By Agent? Provide details of agent processes.
- Direct Mail? Provide details of direct mail processes.  
(certify that application will be taken/processed by Florida licensed agent)
- By Electronic/Internet? Provide details of how the applicant will review information given on line. Submit all screen shots.

#### **For all electronic processing please provide the following:**

- A detailed description of any information to be transmitted electronically.
- An explanation of how the signature pad will be used.
- State whether the applicant will be reviewing all of the health questions.
- State whether the applicant will see his/her signature.
- Certify that the applicant's signature will not be transmitted to any other forms.
- How will the policy/certificate be delivered?

The Office requires printouts of every screen used in the application process.  
(all screen shots)

How is replacement handled? Please demonstrate compliance with Rule 69O-151.104, F.A.C.

Telemarketing/Phone? Provide telephone solicitation script. Give details of how information will be requested and what processes are in place for replacement questions. Certify that information will only be taken by a Florida licensed agent.

**4. Statement of Variability:**

Bracket all variable material. Provide an explanation of variability that states all language possibilities, all ranges of dates, time frames and benefit amounts.

**5. Foreign Travel:**

Certify compliance with Section 626.9541(1)(dd), F.S.

**6. “War” declared or undeclared:**

Florida does not permit the definition of “War” to include terrorism. Please provide certification that the definition of “War” does not include terrorism.

**7. Formatting: Section 627.602, F.S. / 627.452(4), F.S.**

Provide details to any style changes. Certify the font size will never be less than 10 points.

**8. Flesh Score: Section 627.4145(3), F.S.**

Signed by an Officer

**9. Current Authorization:**

Provide a Certificate of Authorization to file on behalf of company, signed by a company Officer within the past year.

**10. TPA:**

Identify any Third Party Administrators

**11. Actuarial Memorandum: Rule 69O-149.021(1)(b)(6), F.A.C.**

**12. Contact Information:**

Provide the name and direct phone number with extension of all persons to be contacted with filing submission questions.

## 2008 Filing Requirements

### **Individual Health**

1. Cover Letter
2. Universal Standard Data Letter/OIR-B2-1507\*
3. Forms Checklist\*
4. Outline of Coverage
5. Policy
6. Application
7. Riders
8. Rates
9. Actuarial Memorandum

### **Group Health**

1. Cover Letter
2. Universal Standard Data Letter/OIR-B2-1507\*
3. Forms Checklist\*
4. Group Policy
5. Group Certificate
6. Master Application
7. Enrollment Form
8. Riders
9. Rates
10. Actuarial Memorandum

### **Out-of-State Group Life & Health**

1. Cover Letter
2. Universal Standard Data Letter/OIR-B2-1507\*
3. Master Policy
4. Group Certificate
5. Actuarial Memorandum & rates if group formed for purposes other than insurance
6. Certification of Compliance with Section 627.6515(5), F.S. (Health)
7. Certification of Compliance with Section 627.5515(5), F.S. (Life)
8. Certification that Florida Licensed agent will service the certificate

### **Discount Medical Plans**

1. Cover Letter
2. Universal Standard Data Letter/OIR-B2-1507\*
3. Membership Agreement
4. Enrollment Form
5. Pricing Filing Form

### **Individual Life**

1. Cover Letter
2. Universal Standard Data Letter/OIR-B2-1507\*
3. Forms Checklist\*
4. Policy
5. Application
6. Riders/Actuarial Memorandum
7. Certification for Valuation Standards (optional)
8. Certification of Nonforfeiture Standards (optional)
9. Policy Summary/Contract Summary

### **Group Life**

1. Cover Letter
2. Universal Standard Data Letter/OIR-B2-1507\*
3. Forms Checklist\*
4. Group Policy
5. Group Certificate
6. Master Application
7. Enrollment Forms
8. Riders
9. Actuarial Memorandum
10. Certification of Valuation Standards (optional)
11. Certification of Nonforfeiture Standards (optional)
12. Policy Summary/Contract Summary

### **Advertisements: Long-Term Care, Medicare Supplement, and Small Group**

1. Cover Letter
2. Universal Standard Data Letter/OIR-B2-1507\*
3. Forms Checklist\*
4. All Advertisements to be reviewed

### **Foreign Language Filings**

Additionally submit the following for any forms that will be used in any language other than English. All forms must contain a disclaimer statement that the English version will prevail if there is ever a discrepancy with the translated version.

1. Translation Certification
2. Copy of the English version of the Forms
3. Translated version of the Forms, e.g., Spanish Policy, Riders, Endorsements

\*Part of the Mandatory I-Filing Assembly & Submission Process @ <https://iportal.fldfs.com/ifile/default.asp>



February 25, 2008

Mr. Scott Sheffer, Associate Consultant  
ABC Life Insurance Company  
1020 Central, Suite 201  
Kansas City, MO 64105-2755

Re: Amendment of Certificate of Authority Due to Name Change for ABC Life Assurance Corporation

Dear Mr. Sheffer:

Please be advised that the requested name change for ABC Life Assurance Corporation has been accepted by the Office of Insurance Regulation ("Office"). Our records have been updated and now reflect the following name: ABC Life Insurance Company.

Please find enclosed an amended Certificate of Authority evidencing the new name. For financial matters, this company is assigned to George Albritton, Insurance Examiner. Mr. Albritton can be contacted at (850) 413-2530. This Certificate of Authority will remain in force subject to payment of the annual renewal fee and compliance with state rules and regulations. Each year the company will receive a renewal license fee invoice that includes a listing of its authorized lines of business.

The Company is required to submit a name change endorsement form for approval to the Office, Life & Health Product Review, to the attention of Gary Edenfield. Upon approval, this endorsement should then be mailed by your Company to each insured to notify them of the name change.

Pursuant to Section 627.410, Florida Statutes, as a result of this name change, the insurer's policy forms will need to be modified to reflect this name change and must be approved by the Office before they can be used in Florida. There are two options available to accomplish this. **The first option is for the insurer to submit all forms and rates for individual approval. The second option is for the insurer to enter into a consent order in which the Office approves all prior approved forms and rates under the new name.** The insurer may continue to use the old policy forms, with the name change endorsement, for a period of ninety (90) days after the date the Consent Order is executed by this Office or the re-filed forms have been approved. When submitting the name change endorsement please state which of these options the Company will exercise in having its policy forms approved. If option two is chosen, you must provide, along with the name change endorsement, a list of forms you will modify with the name change.

Please note: Option two can only be used if the name change is the only modification being made to the form(s).

If you have any questions regarding the above, please call Gary Edenfield, Life and Health Product Review, at 850-413-5134.

Sincerely,

Insurance Examiner



## **Exempt Mandated Benefits for Hospital Type Indemnity Policies**

**Diabetes Treatment** 627.65745, F.S.

**Children: Newborn Coverage** 627.6575, F.S.

**Child Health Supervision Services** 627.6579, F.S.

**Mastectomy: Length of stay and out-patient coverage** 627.66121, F.S.

**Mastectomy: Surgical Procedures and Devices** 627.6612, F.S.

**Mammograms** 627.6613, F.S.

**Ambulatory Surgical Centers** 627.6616, F.S.

**Conversion to Individual Coverage** 627.6675, F.S.

**Osteoporosis** 627.6691, F.S.

**Cleft Lip and Cleft Palate for Children** 627.66911, F.S.

## List of Mandated Health Insurance and HMO Benefits

The term “mandatory health insurance benefits” is subject to different interpretations. Broadly interpreted to include any coverage requirement, mandatory benefits include: (1) required policy benefits; (2) required offer of benefits; (3) required payment to a class of providers; and (4) required coverage of insureds and other underwriting restrictions. Florida has currently mandated health benefits for each of these categories be as follows:

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
1.	Acupuncturists	If a policy provides coverage for acupuncture, the policy must cover the services of an acupuncturist certified pursuant to chapter 457 under the same conditions that apply to services of a licensed physician.	627.6403	627.6618 Small group: 627.6699(12)(b)7	Not required	Not Required	Not Required
2.	Ambulatory Surgical Centers	A policy must provide coverage for any service performed in an ambulatory surgical center, as defined in s. 395.002, if such service would have been covered as an eligible inpatient service.	627.6056	627.6616 Small group: 627.6699(12)(b)7	Not required	Not Required	627.6616
3.	Birthing Centers and Nurse Midwives	A policy or HMO contract that provides coverage for maternity care must cover the services of certified nurse midwives and midwives licensed under chapter 467, and birth centers licensed under ss. 383.30-383.335.	627.6406	627.6574 Small group: 627.6699(12)(b)7	641.31(18)	627.6515(2)(c)	627.6699(12)(b)7
4.	Bone Marrow Transplants	The policy may not exclude coverage for bone marrow transplant procedures recommended by referring and treating physicians under a policy exclusion for experimental or investigative procedures if the particular use of the procedure is determined to be accepted within the appropriate oncological specialty and not experimental pursuant to rules adopted by the Agency for Health Care Administration, based on the recommendations of an advisory panel. Procedures must include costs associated with the donor-patient.	627.4236	627.4236	627.4236	Not required	627.4236 (But limited coverage provided in Standard)

5.	Cancer Drugs	If a policy covers the treatment of cancer, an insurer may not exclude coverage for any prescribed drug on the ground that the drug is not approved by the U.S. Food and Drug Administration, if that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medial literature, unless the FDA has determined that the use of the drug is contra-indicated or has not otherwise approved the drug for any indication.	627.4239	627.4239	Not required	Not required	Not required
6.	Child Health Supervision Services	Policy benefits for children must include coverage for child health supervision services from birth to age 16 and be exempt from any deductible. Services include a physical examination, developmental assessment and anticipatory guidance, and immunizations and laboratory tests, consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.	627.6416	627.6579	641.31(30)	627.6515	627.6699(12)(b)4
7.	Children: Adopted and Foster Children	Benefits applicable to children apply to an adopted child and foster child from the moment of placement in the residence. Coverage begins at the moment of birth if a prior written agreement to adopt the child has been executed. The policy may not exclude coverage for any preexisting condition except in the case of a foster child. For HMOs and small group policies, only the benefits applicable to adopted children apply.	627.6415	627.6578 Small group: 627.6699(12)(b)4 (adopted only)	641.31(17) (adopted only)	Not required	627.6578(12)(e)
8.	Children: Handicapped	Policies covering children must continue to provide coverage beyond the age limit for dependent children as long as the child continues to be incapable of self-sustaining employment due to mental retardation or physical handicap; and is chiefly dependent on the policyholder or subscriber for support.	627.6615	627.6578 & 627.6615 Small group: 627.6699(12)(b)4	641.31(29)	Not required	627.6699(12)(b)4
9.	Children: Newborn Coverage	Policies covering a family member of the insured must provide coverage for a newborn child from the moment of birth. The policy must also cover the newborn child of a covered family member (son or daughter), which coverage terminates 18 months after birth.	627.641	627.6575 Small group: 627.6699(12)(b)4	641.31(9)	627.6515(2)(c)	627.6699(12)(b)4

10.	Children: Dependent Coverage to Age 25	Group health insurance policies that insure dependent children must continue coverage at least until the end of the calendar year in which the child reaches age 25 if the child is dependent upon the policyholder or certificateholder for support and the child is either living in the household of the certificateholder or is a full-time or part-time student.	Not required	627.6562	Not required	Not required	Not required (But included in the policy)
11.	Chiropractors	A health insurance policy must be construed to include payment to a chiropractic physician who provides covered benefits or procedures within the scope of his or her license. (Not applicable to HMOs.)	627.419(4)	627.419(4) Small group: 627.6699(12)(b)7	Not required	627.419(4)	627.6699(12)(b)7
12.	Cleft Lip/Palate for Children	Policy benefits for a child under age 18 must include treatment of cleft lip and cleft palate, including medical, dental, speech therapy, audiology, and nutrition services if prescribed by the treating physician or surgeon and certified as medically necessary.	627.64193	627.66911 Small group: 627.6699(12)(b)7	641.31(35)	627.6515(2)(c)	627.6699(12)(b)7
13.	Continuation of Group Coverage	Group policies covering fewer than 20 employees must allow an employee to continue coverage for 18 months (or 29 months for handicapped individuals; 36 months for divorced and widowed spouses) after their group coverage would otherwise terminate, subject to payment of up to 115% of the group premium. (Comparable to the federal COBRA law for employers with 20 or more employees.)	Not required	Small group: 627.6692	Small group: 627.6692	Not required	Small group: 627.6692
14.	Continued Coverage with Terminated Provider	If a contract between an HMO and a provider is terminated for any reason other than for cause, each party shall allow HMO subscribers for whom treatment was active, to continue coverage through completion of medically necessary treatment, until the subscriber picks another provider, or during the next open enrollment period offered by the HMO, not to exceed 6 months or through postpartum care if pregnant.	Not required	Not required	641.51(8)	Not Required	Not Required
15.	Conversion to Individual Coverage	After group coverage (large or small) terminates (after any COBRA extension), the insurer or HMO must offer an individual conversion policy.	Not required	627.6675	641.3921 & 641.3922	627.6515(2)(c)	Not required (But included in the policy)

16.	Denial of Coverage due to Breast Cancer	An insurer or HMO may not exclude or deny coverage solely because the insured has been diagnosed as having a fibrocystic condition or a nonmalignant lesion that demonstrates a predisposition to, or solely due to a family history of, breast cancer, unless the condition is diagnosed through a breast biopsy that demonstrates an increased disposition to developing breast cancer. Coverage also may not be denied nor canceled solely due to breast cancer if the insured has been free from breast cancer for more than 2 years before request for coverage.	627.6419	627.6419	627.6419	Not required	Not required
17.	Dental Care (Employer Offer of Open-Panel Plan)	Any employer, group, or organization that pays or contributes to the premiums of a group health plan or dental service plan which provides dental coverage only through an exclusive list of dentists must provide an alternative to enable the insured to have a free choice of dentist. (Note: This requirement applies to employers, not insurers.)	Not required	627.6577	Not required	Not Required	Not Required
18.	Dental Procedures for Children: General	If the policy provides coverage for general anesthesia and hospitalization services, such services must be provided for dental care to a person under age 8, if the dental condition is likely to result in a medical condition if left untreated and if the child's dentist and physician determine dental treatment in a hospital or ambulatory surgical center is necessary due to the complex nature of the procedure or due to a significant or undue medial risk.	627.4295	627.65755	641.31(34)	627.6515(8)	Not Required
19.	Dentists	The word "physician" when used in a health insurance policy providing for the payment of surgical procedures performed in an accredited hospital in consultation with a licensed physician must be construed to include payment to a dentist who provides benefits or procedures within the scope of his or her license.	627.419(2)	627.419(2) Small group: 627.6699 (12)(b)7	Not required	627.419(2)	627.419(2)
20.	Dermatologists (Direct Access)	HMO contracts and insurer EPO contracts must provide direct access (without referral or authorization) for up to five office visits annually, including minor procedures and testing, to a dermatologist who is under contract with the insurer or HMO.	627.6472(16)	627.6472(16) & 627.662	641.31(33)	Not Required	Not Required

21.	Diabetes Treatment	Policy must cover all medically appropriate and necessary equipment, supplies, and diabetes outpatient self-management training and educational services used to treat diabetes, if the treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary.	627.6408	627.65745	641.31(26)	Not Required	627.65745
22.a.	Emergency Care (EPO)	Insurers issuing exclusive-provider organization (EPO) contracts must cover non-exclusive providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.	627.6472	627.6472	Not Required	Not Required	Not Required
22.b.	Emergency Care (HMO)	HMOs must provide coverage, without prior authorization, for emergency care (screening and stabilization) based on determination by hospital physician or appropriate licensed professional hospital personnel under supervision of physician, provided by either a participating or nonparticipating provider.	Not required	Not required	641.513(3) & 641.31(12)	Not Required	641.513(3) & 641.31(12)
23.	Enteral Feeding Formulas/ Treatment of PKU	The policy must make available to the policyholder (e.g., to an employer under a group policy) as part of the application, for an appropriate additional premium, coverage for prescription and non-prescription enteral formulas (nutrient and food supplements) for home use which are prescribed by a physician as medically necessary for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism or for malabsorption originating from congenital defects or acquired during the neonatal period. The coverage may not exceed \$2,500 per year for an insured through age 24.	627.42395	627.42395	Not required	Not Required	Not Required
24.	Extension of Benefits	Group policy must provide for a 12-month extension of major medical benefits for a person who is totally disabled at the date of discontinuance of the policy, regardless of whether replacement coverage is obtained. Specific requirements apply to extension of benefits for maternity expense and dental procedures. (The requirements for dental procedures do not apply to HMOs.)	Not required	627.667	641.3111	627.6515(2)(c)	Not Required (But included in the policy)

25.	Guaranteed Availability of Individual Coverage (HIPAA-Eligible)	Persons who lose coverage after being covered for at least 18 months, the most recent of which is group coverage, are entitled to individual coverage. If the prior coverage is under an insured group plan, the group insurer must offer an individual conversion policy. If the prior coverage is with a self-insured plan, coverage may be obtained on a guaranteed-issue from any insurer or HMO issuing individual coverage. Persons who lose eligibility for individual coverage issued in Florida due to the insurer becoming insolvent, the insurer discontinuing all coverage in the state, or the individual moving out of the service area of the insurer or HMO, are entitled to guaranteed-issuance of coverage from any individual carrier.	627.6487	627.6487	627.6487	627.6487	627.6487
26.	Guaranteed Renewability	All individual and group policies and group HMO contracts must be guaranteed renewable, subject to certain exceptions.	627.6487	627.6571 Small group: 627.6699(7)	641.31074	627.6571 (Small group and bona fide associations)	627.6699(7)
27.	HIV Coverage	A policy may not exclude coverage for HIV-infection or acquired immune deficiency syndrome, except as provided in a preexisting condition exclusion.	627.411; 627.429	627.411; 627.429 Small group: 627.6699(6)(d)	641.3007	627.429	627.429 & 641.3007
28.	Home Health Care Services	A group policy must provide coverage of a least \$1,000 per year for home health care by a licensed home health care agency, as prescribed by a licensed physician.	Not required	627.6617	Not required	Not Required	Not Required (But required in the policy)
29.	Mammograms	Policy must include coverage for a baseline mammogram for a woman age 35-39, a mammogram every two years for a woman age 40-49, every year for a woman age 50 or older, and one or more a year based on a physician's recommendation for a woman who is at risk for breast cancer based on specified criteria.	627.6418	627.6613 Small group: 627.6699(12)(b)4	641.31095	627.6515(2)(c)	627.6418 & 641.31095
30.	Massage Therapists	If a policy or HMO contract provides coverage for a massage, it must cover the services of a person licensed to practice massage under chapter 480, if the massage is prescribed as medically necessary by a physician licensed under chapters 458, 459, 460, or 461, and the prescription specifies the number of treatments.	627.6407	627.6619	641.31(37)	Not Required	Not Required



31.	Mastectomy: Length of stay and out-patient coverage	A policy that provides coverage for breast cancer may not limit in-patient hospital coverage for mastectomies to any period that is less than that determined by the treating physician to be medically necessary in accordance with prevailing medical standards and after consultation with the insured patient. Must also provide coverage for outpatient post-surgical follow-up care in keeping with prevailing medical standards by a licensed health care professional qualified to provide such care.	627.64171	627.66121 Small group: 627.6699(12)(b)7	641.31(31)	627.6515(2)(c)	627.6699(12)(b)7
32.	Mastectomy: Surgical Procedures and Devices	If the policy provides coverage for a mastectomy, coverage must include prosthetic devices and breast reconstructive surgery incident to a mastectomy.	627.6417	627.6612 Small group: 627.6699(12)(b)7	641.31(32)	627.6515(2)(c)	627.6699(12)(b)7
33.	Maternity Care: Length of Stay and Post-Delivery Care	A policy that provides coverage for maternity benefits or newborn coverage may not limit coverage for length of stay in a hospital or for follow-up care outside of a hospital to any time period less than that determined to be medically necessary by the treating obstetrical care provider or the pediatric care provider, in accordance with prevailing medical standards. The policy must provide coverage for post-delivery care for the mother and infant, including medically necessary clinical tests and immunizations.	627.6406	627.6574 Small group: 627.6699(12)(b)7	641.31(18)	627.6515(2)(c)	627.6699(12)(b)7
34.	Mental and Nervous Disorders	Insurers and HMOs must make available to a group policyholder (e.g., the employer) as part of the application, for an appropriate additional premium, coverage for mental and nervous disorders. If mental health benefits are elected, coverage must include at least 30 days of in-patient coverage and at least \$1,000 per year for outpatient benefits for consultations with a licensed physician, psychologist, mental health counselor, marriage and family therapist, and clinical social worker.	Not required	627.668 Small group: 627.6699(12)(b)7	627.668	Not Required	627.668 (But with different limits)
35.	Newborn Hearing Screening	Policies covering a family member of the insured must provide coverage for the initial hearing screening and any medically necessary follow-up reevaluations leading to diagnosis shall be a covered benefit. Medicaid recipients' services (including those in Medicaid HMOs or PSNs) will be reimbursed as fee-for-service (Medicaid rate) and other insurers will be reimbursed at the contracted rate.	627.6416	627.6579	641.31(30)	627.6515(2)(c)	627.6699(12)(b)4d

36.	Nurse Anesthetist	HMO contracts that provide anesthesia coverage or services shall offer to the subscriber if requested and available, the services of a licensed certified registered nurse anesthetist.	Not required	Not required	641.31(21)	Not Required	Not Required
37.	OB/GYN Annual Visit	Insurers issuing EPO contracts and HMOs must allow, without prior authorization, a female subscriber to visit a contracted OB/GYN for one annual visit and for medically necessary follow-up care detected at that visit.	627.6472(18)	627.6472(18) & 627.662	641.51(11)	Not Required	Not Required
38.	OB/GYNs	HMO must allow each female subscriber to select as her primary physician an obstetrician/gynecologist. (Also see Table 1, OB/GYN Annual Visit)	Not required	Not required	641.19(13)(e)	Not Required	HMO only: 641.19(13)(e)
39.	Ophthalmologist	Insurance policy and HMO contracts which provide coverage or services that are performed by physicians who are ophthalmologists, licensed under chapter 458 or 459, must offer the subscriber the services of an ophthalmologist.	627.419(2)	627.419(2)	641.31(20)	627.419(2)	627.6699(12)(b)7
40.a.	Optometrists	A health insurance policy that provides coverage for services within the scope of an optometrist's licenses shall be construed to include payment to an optometrist who performs such procedures.	627.419(3)	627.419(3) Small group: 627.6699(12)(b)7	Not required	627.419(3)	627.6699(12)(b)7
40.b.	Optometrists (HMO)	HMO contracts that provide coverage or services as described in s. 463.002(5), must offer to the subscriber the services of an optometrist licensed under chapter 463.	Not required	Not required	641.31(19)	Not Required	627.6699(12)(b)7
41.	Osteopathic Hospitals	Small employer policies and HMO contracts that provide for inpatient and outpatient services by allopathic hospitals must provide as an option for the patient or subscriber similar inpatient and outpatient services by an osteopathic hospital when the services are available in the HMO service area.	Not required	Small group only: 627.6699(12)(b)8	641.31(24)	Not required	Not required (But included in the policy)
42.a.	Osteopaths	For insurance policies a physician licensed under chapter 459 (osteopaths).	627.419(2)	627.419(2)	641.19(13)(d)	627.419(2)	Not required (But included in the policy)
42.b.	Osteopaths (HMO)	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.	Not required	Not required	641.19(13)(e)	Not required	Not required

43.	Osteoporosis Diagnosis and Treatment	Policy must provide coverage for the medically necessary diagnosis and treatment of osteoporosis for high-risk individuals, including individuals with a family history of osteoporosis and other specified high-risk criteria.	627.6409	627.6691	641.31(27)	Not Required	Not Required
44.	Out-of-Hospital Services	Policy must provide coverage for treatment provided outside a hospital if such treatment would be covered on an in-patient basis and is provided by a health care provider whose services would be covered under the policy if performed in a hospital.	627.4232	627.4232	Not required	Not Required	Not Required
45.a.	Podiatrists	A health insurance policy that provides coverage for services within the scope of a podiatrist's license shall be construed to include payment to a podiatrist who performs such procedures.	627.419(3)	627.419(3) Small group: 627.6699(12)(b)7	Not required	627.419(3)	627.6699(12)(b)7
45.b.	Podiatrists (HMO)	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.	Not required	Not required	641.19(13)(e)	Not required	627.6699(12)(b)7
46.a.	Preexisting Conditions	Individual health insurance policies and individual HMO contracts may not exclude preexisting conditions for more than 24 months and may relate only to conditions that manifested themselves during the 24-month period before coverage. However, the policy may exclude coverage for named or specific conditions without any time limit.	627.6045 & 627.607	Not required	4-191.024(17) (Individual only)	Not required	Not required
46.b.	Preexisting Conditions	Group policies and group HMO contracts may not exclude preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee, and may relate only to conditions that manifested themselves during the 6-month period prior to coverage. The period of the exclusion is reduced by the time the insured was covered under prior creditable coverage.	Not required	627.6561	641.31071	Not required	627.6699(5)(f)
47.	Primary Care Physicians	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.	Not required	Not required	641.19(13)(e)	Not Required	Not Required

48.	Psycho-therapeutic Providers	An insurer issuing coverage through preferred providers (PPO policies) or through exclusive providers (EPO policies) that cover psychotherapeutic services, must provide eligibility requirements for all groups of health care providers licensed under chapter 458, 4359, 490 or 491, which include psychotherapy in their scope of practice, and certified advanced registered nurse practitioners in psychiatric mental health under s. 464.012.	627.6471 & 627.6472	627.6471, 627.6472 & 627.668	Not required	Not required	Not required
49.	Special Enrollment Periods	Insurers and HMOs issuing group health policies and contracts must: 1) allow an employee to enroll who previously did not enroll due to having other coverage, and the other coverage terminates due to certain conditions; 2) allow a person to enroll who becomes a dependent of a covered person by reason of marriage, birth, or adoption.	Not required	627.65615	641.31072	Not required	627.6699(5)(h)7
50.	Substance Abuse	Insurers and HMOs must make available to a group policyholder (e.g., the employer) as part of the application, specified benefits for substance abuse, subject to the right of the applicant to select any alternative benefits as may be offered. The specified level of benefits that must be offered must have a minimum lifetime benefit of \$2,000, a maximum of 44 out-patient visits, and a maximum benefit of \$35 per outpatient visit. Treatment must be provided by, or under the supervision of, or prescribed by, a licensed physician or psychologist.	Not required	627.669	627.669	Not Required	Not Required
51.	TMJ	A policy that provides coverage for any diagnostic or surgical procedure involving bones or joints of the skeleton may not discriminate against coverage for such procedures involving bones or joints of the jaw and facial region if such procedure or surgery is medically necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.	627.419(7)	627.65735	641.31094	627.6515(7)	Not Required (But included in the policy)