Gold Coast School of Insurance

Life, Health & Variable Contracts

Course Outline
(Blended)

Based on the 32nd Edition
Florida State Study Manual

PABC
Professional Agents Brokers and Compnaies Assoc., Inc.
Florida DFS Provider #: 753

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Congratulations on starting your new career in insurance and choosing Gold Coast as your school. Gold Coast is one of Florida's leading insurance schools and has helped thousands of students like you since 1970! As with learning anything new, the volume of material can seem somewhat daunting. Remember, thousands of students before you have completed the course, and you can too!

The key to passing this course and the state exam, on your first attempt, is preparation. We STRONGLY recommend that you read each chapter carefully, learn each of the key terms, and carefully answer the review and practice exam questions at the end of each unit.

This book is intended to be an educational resource. It is not in any way intended as a substitute or replacement for the rules and statues of the State of Florida.

The authors do not intend to give legal or accounting advice. If you are involved in a situation or transaction that requires a legal or financial opinion, we recommend that you seek the advice of a properly licensed attorney or accountant.

We want to personally thank you for choosing Gold Coast and wish you the best with your new career. If you have any questions or suggestions to improve this material or the course, we would like to hear from you. Please send all comments to kmilner@goldcoastschools.com.

Feedback from previous students is invaluable for future students.

Now let's get started.

Sincerely,

James Greer, DBA
Gold Coast Owner

Kevin R. Milner, MBA, CIC, ITP
Insurance Program Director

5600 Hiatus Road • Tamarac, FL 33321 • Tel 800.732.9140 • Fax 954.731.9226
www.GoldCoastSchools.com

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Gold Coast School of Insurance

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Table of Contents

Law Units

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Be Prepared For Your State Examination

Health and Life Insurance and Annuity (Including Variable Contracts) Exam (2-15 License)

- 2¾ hour time limit (165 minutes)
- 150 scored questions
- 15 random unscored 'pretest' questions

Life Insurance and Annuity (Including Variable Contracts) Exam (2-14 License)

- 2 hour time limit (120 minutes)
- 85 scored questions
- 15 random unscored 'pretest' questions
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Health (2-40 License)

- 2 hour time limit (120 minutes)
- 85 scored questions
- 15 random unscored 'pretest' questions

Note: Answer all questions. Any unanswered question will be marked as incorrect.

To schedule an appointment for fingerprinting, visit www.myfloridacfo.com/Division/Agents/ & click on "Fingerprinting" under the "quick links" menu.

To register for the state exam, visit Pearson Vue at www.pearsonvue.com/fl/insurance or contact them at (888) 204-6289

For special accommodations please call: (800) 466-0450
Department of Financial Services: (850) 413-3137
Testing site information: Pearson Vue (888) 204-6289 or www.vue.com

FL Statute 626.833 – NO PERSON employed by the US Department of Veterans Affairs shall be licensed as a Health Agent.

During this course, we will be covering the required material to assure that you meet the proper certification guidelines. However, due to the high concentration of these time constraints, **we strongly encourage that you read the state manual** (cover to cover), at least once prior to taking your state exam.

As always, your instructor will be available to answer any questions that you may have.

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Retirement Planning

Basic Assumptions

- Retirement at age 65
- Retirement Income of $50,000 per year in today's dollars using a 2% inflation adjustment
- Retirement Income provided from age 65 to age 85
- Each age category starts with some savings that they have accumulated over the year through IRA's, 401K's, Private savings accounts, etc.

These assumptions are as follows:

25 year olds - $5,000

35 year olds - $15,000

45 year olds - $50,000

55 year olds - $150,000

Illustration A assumes all current money and new money will earn 9% during your working years and 7% during retirement years.

Illustration B assumes all current money and new money will earn 8% during your working years and 6% during retirement years

$50,000 Annual Income Adjusted by 2% Inflation

Age	Illustration A - 9%-7%	Illustration B - 8%-6%
25	($110,401 @65) ($165,051@85) Need to save $298.37 per month	Need to save $442.92 per month
35	($90,568@65) ($134, 579@85) Need to save $565.49 per month	Need to save $787.01 per month
45	($74,297@65) ($110,401@85) Need to save $1,052.91 per month	Need to save $1,406.27 per month
55	($60,949@65) ($90,568@85) Need to save $2, 248.52 per month	Need to save $2,907.76 per month

Exhibit "A" Annuities

Seven (7) Annuity Options Based on a sum of $300,000*

Straight Life AKA "Life-Only"	Cash Refund	Installment Refund	Life with "Period Certain"	Joint with "full Survivor"	Joint w/ Survivor and 3/4 or 2/3 or 1/2	Period Certain 10 or 20 or 30yrs
Cannot outlive Income	Cannot outlive Income	Cannot outlive Income	Cannot outlive Income	Cannot outlive Income	Cannot outlive Income	**Can** Outlive Income
Pays out the Highest Amount			If Annuitant has elected a guaranteed 15 year Payment period		Survivor's Income reduced to elected 3/4 or 2/3 or 1/2 of original monthly payment	If Annuitant has elected a guaranteed 30-year payment period
$3,000/month*	$2,500/month*	$2,750/month*	$2,450/month*	$2,000/month*	$2,200/month*	
Annuitant Dies: Payment Stops	Annuitant Dies: Beneficiary will receive unpaid remaining balance of the original $300,000 in *One Single Cash Lump Sum*	Annuitant Dies: Beneficiary will receive unpaid remaining balance of the original $300,000 in *Same Monthly Payment* until Entire $300,000 has been fully refunded	Annuitant Dies after only 5yrs: Beneficiary will continue to receive same monthly payment for remaining 10yrs Annuitant still alive after 15yrs… Monthly Payments will continue until Annuitant dies.	Annuitant Dies: Surviving Spouse will continue to receive *same* monthly payment until *s/he dies*	Annuitant Dies: Surviving Spouse will continue to receive r*educed* monthly payments *until s/he dies*	Will Pay Annuitant only for that 30yrs period. If Annuitant outlives 30-year payment period: Payment stop Example: Lottery Structured Payment

UNIT

26

FLORIDA LAWS & RULES: LIFE & HEALTH INSURANCE

OVERVIEW

This unit describes Florida's regulation of the life and health insurance business, its companies, and their marketing practices. Candidates for either the Life and Annuity Insurance Examination or the Health Insurance Examination, or both, will be tested on the various required laws and rules covered in this unit. This content of this unit applies to candidates seeking licensure in Life and Annuity Insurance, Health Insurance, or both. The content found in Units 26 – 30 will comprise of approximately 33% (50 questions) of your state exam

OBJECTIVES

After completing this chapter, you should be able to understand:

- Financial Services Regulation
- Licensing
- Agent Responsibilities
- Insurance Guaranty Fund
- Marketing Practices
- Rule 69B-215, F.A.C., Code of Ethics NAIFA

KEY TERMS

Admitted Versus Non-admitted Insurers
Agent Responsibilities
Chief Financial Officer
Code of Ethics of the NAIFA
Defamation
Insurance Code
Insurance Regulatory Agencies
Misrepresentation
Office of Insurance Regulation
Rebating

QUESTIONS IN STATE STUDY MANUAL 20 (Twenty)

I. Financial Services Regulation

A. Chief Financial Officer (CFO) [Sec. 20.121]

1. About the CFO
   a. Independently Elected Official
   b. Member of Governor's Cabinet
   c. Head of DFS
   d. Member of Financial Services Commission
2. The CFO directly oversees a multitude of divisions and agencies
   a. Division of Accounting & Auditing (Bureau of Unclaimed Property)
   b. Division of Insurance Agents and Agency Services
   c. Division of Insurance Fraud
   d. Division of Consumer Services
   e. Office of the Insurance Consumer Advocate

Each of these divisions/agencies are directly administered by the CFO and have a role in regulating insurance.

B. Financial Services Commission [Sec. 20.121]

1. The Financial Services Commission is composed of:
   a. Chief Financial Officer (CFO)
   b. Attorney General (AG)
   c. Commissioner of Agriculture
   d. The commission, made up of all of its components, supervises the Office of Insurance Regulation (OIR) and Office of Financial Regulation (OFR).
2. Office of Financial Regulation (OFR)
   a. Responsible for all activities of the Financial Services Commission relating to the regulation of:
      i. Banks
      ii. Credit Unions
      iii. Other Financial Institutions
      iv. Financial Companies
      v. Securities Industry
   b. The OFR may investigate any suspected wrongdoing, both inside and outside of Florida. It may also refer suspected violations of criminal law to state, federal, and prosecutorial agencies

C. Office of Insurance Regulation (OIR)

1. Head of Office is the Director or Commissioner of Insurance Regulation.
2. Responsible for all activities of the Financial Services Commission (FSC) relating to regulation of insurers and other-risk bearing entities.
3. Specific duties of this office include:
   a. Rate-Making Supervision
   b. Policy Form Approval
   c. Market Conduct Investigation
   d. Issuance of Company 'Certificates of Authority'
   e. Company Solvency
   f. Viatical Settlements
   g. Premium Financing
   h. Administrative Supervision

II. Department of Financial Services

A. General Duties and Powers [Sec. 624.307]

1. The Department and respective offices of the DFS have the following powers and duties
    a. Enforce Insurance Code
    b. Exercise ones' duties set forth by the code
    c. Powers and Authority (two forms)
        i. Expressed
        ii. Implied
    d. Conduct Investigation
        i. Determination of code violation
        ii. Obtain Information necessary to administer the code
    e. Publish, disseminate, propose, promulgate information regarding duties imposed upon by the code
    f. Additional powers and duties as provided by other laws of the State of Florida
    g. DFS, its departments and offices, may employ actuaries. Must be from either:
        i. Society of Actuaries
        ii. Casualty Actuarial Society
    h. Florida licensed insurers must designate the CFO as their attorney to receive service of all legal process issued against them in any Florida civil action. [SEC. 624.422]
    i. May utilize funds within existing resources for professional development and to ensure compliance with NAIC regulations and training.
    j. Develop an outreach program to encourage additional insurers into the Florida insurance market.
    k. May send legal documents by trackable means to individuals or to unauthorized carriers.
    l. May receive inquires and complaints from consumers, provide follow-up and consumer assistance administered penalties, and adopt rules to administer this section.
2. Policyholders' Rights **[Sec. 626.9641]**
    a. Set Standards to be followed by the Department, Commission, and designated offices.
    b. List of Policyholder Rights
    c. Policyholders shall have the right to …
        i. Competitive pricing practices and marketing methods
        ii. Obtain comprehensive coverage
        iii. Fair and accurate insurance advertising
        iv. Selling approaches that provide accurate and balanced information
        v. An insurance company that is
            (1) financially stable
            (2) able to supply a competent, honest, insurance agent/broker to service their clients
            (3) able to provide an economic delivery of coverage and that tries to prevent losses
        vi. Readable Insurance Policy
        vii. Balanced and positive regulation by the Department, Commission, and Office.

III. Office of Insurance Regulation

A. Additional Duties and Powers of the OIR

1. Policy Approval Authority Rates and Forms **[Sec. 624.302, 627.410, Rule 69O-149.002-023]**
    a. Types of policies that need rate filings
        i. Basic Insurance Policy
        ii. Annuity Contract
        iii. Application Form

iv. Group Insurance
v. Riders & Endorsements
vi. Renewal Certificates

b. Policies may not be delivered in Florida unless the forms have been submitted and approved by the Office
i. 30 days in advance of delivery
ii. Expiration of 30 days
(1) Form is deemed approved unless disapproved by Office.

c. Health Insurance Company Filing Rule
i. Company cannot deliver, issue for delivery, or renew in Florida any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule.

2. Market Conduct Examinations **[Sec. 624.316, Rule 69O-138.0901]**
a. Company is subject to examination as often as may be warranted
b. Examine each domestic company not less than once (1) every five (5) years.
c. Examination may include examination of
i. Affairs
ii. Transactions
iii. Accounts
iv. Records relating directly or indirectly to
(1) The company
(2) Assets of the Company's MGA
(3) Controlling or controlled person(s)

d. Initial Certificate of Authority to transact insurance in this state
i. Office will examine each insurer applying
ii. Domestic Company
(1) Examination must be conducted at least once (1) every year that has continuously held a Certificate of Authority for less than three years.

3. Agency Actions
a. OIR Major Areas of Responsibility
i. Organizing and licensing of insurers (including establishment of initial financial requirements)
ii. Monitoring for unauthorized insurance activities
iii. Maintain and oversee regulation of company activities
(1) Policy form*
(2) Provision rates*
*Not applicable to Life Insurance
iv. Controlling approaches of obtaining business
(1) Licensing of agents
(2) Control of Unfair Trade and Advertising Practices
v. Monitor the financial condition of insurers
(1) Investment categories
(2) Appropriate methodology for developing liabilities
vi. Liquidation and rehabilitation of insurance companies (where necessary)

4. Investigations
a. DFS or OIR will conduct an investigation if it believes any person has violated, or is violating a provision of the insurance code.
b. Items to be investigated may include
i. Accounts
ii. Records
iii. Documents

iv. Transactions pertaining to any insurance agent, agency, customer service representative, service representative, unaffiliated agent, or other person subject to its jurisdiction
v. Persons having a contract or power of attorney under which they are subject to exclusive or dominant right to manage or control a company or insurance transaction

c. DFS or OIR has the ability to
i. Administer oaths
ii. Examine witnesses
iii. Receive evidence
iv. Subpoena witnesses

d. Any person who willfully obstructs the Department, the Office, or the examiner in any examination or investigation may be guilty of a 'misdemeanor'**. [Sec. 624.317, .318, .321, 626.601]**

IV. Office of Financial Regulation

A. General duties and powers

1. Has supervisory position over
   a. All state financial institutions
   b. Their subsidiaries
   c. Service corporations
2. Office's purpose **[Sec. 655.012]**
   a. Safe and sound business transactions of the financial institutions it oversees
   b. Maintain public confidence in the financial institutions

B. Agency Actions [Sec 655.031]

1. When imposing an action, the Office will consider the appropriateness of the penalty with respect to
   a. the financial resources
   b. good faith
   c. gravity of the violation
   d. previous history of violation
   e. other matters as justice requires

C. Cease and Desist Orders (CDO)

1. Office may issue and serve upon any state financial institution a complaint stating charges whenever the Office has reason to believe that such institution has or is engaging in conduct that is
   a. Unsafe or unsound practice
   b. Violation of any law relating, rule, or order of the commission or Office
   c. Violates a written agreement with the Office
   d. Prohibited act or practice pursuant to **[Sec. 655.0322]**
   e. Willful failure to provide documentation or information to the Office or any appropriate agency, its representatives, upon written request. **[Sec 655.033]**
   f. Complaint
      i. Must include a statement of facts
      ii. Notice of opportunity
      iii. If the recipient of the CDO fails to respond to a complaint within the time allotted, the recipient is in default and justifies the entry of the order
      iv. If the Office find that the conduct of the financial institution is like to cause insolvency, the Office may issue an Emergency Cease and Desist (ECDO) requiring the institution to immediately cease and desist from the conduct

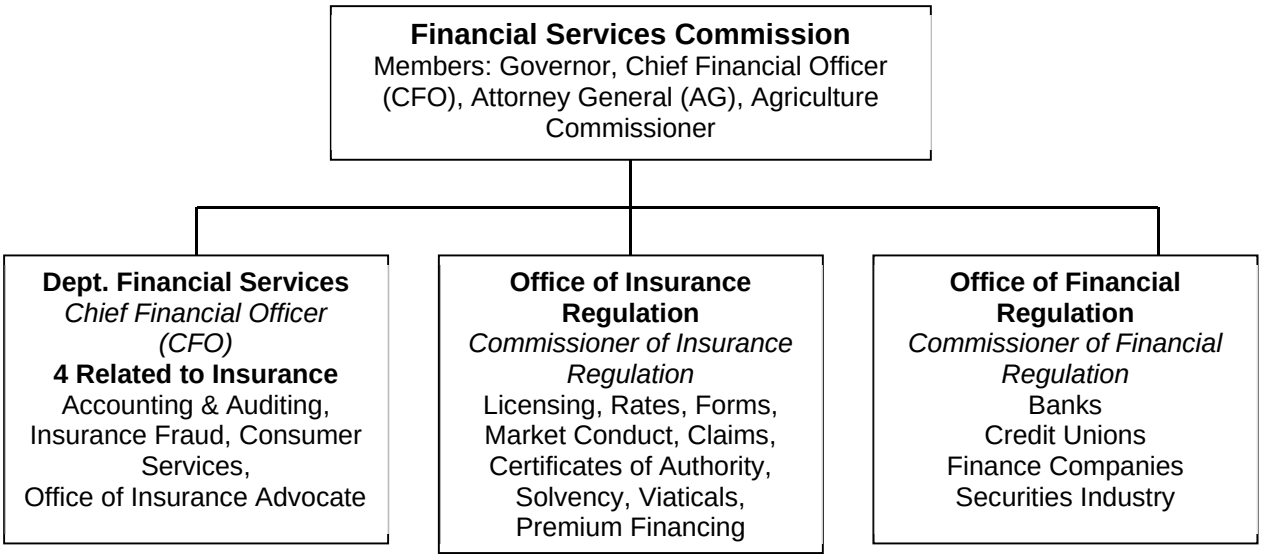
v. The ECDO is effective immediately upon service of the order for a period of 90 days

D. Injunctions [Sec. 655.034]

1. Circuit Court has jurisdiction to hear any compliant by the Office
2. Circuit Court may issue an injunction or the granting of another appropriate relief in the event it feels the violation of the financial institution will cause substantial injury to a state financial institution

E. Investigations

1. The Office may make investigations when it deems necessary
2. In an investigation, the Office has the power to
   a. Administer oaths and affirmations
   b. Take testimony and depositions
   c. Issue subpoenas
3. Non-compliance of a subpoena
   a. Request the Circuit Court to order the recipient of the subpoena to
      i. Appear
      ii. Testify
      iii. Produce books, records and documents
   b. Failure to comply
      i. Contempt of Court (Circuit Court)
      ii. Responsible for reasonable and necessary investigation expenses assessed against the person or entity being investigated **[Sec. 655.032]**



V. Definitions

The following definitions are in addition to the definitions described in Unit 1 and Unit 3.

NOTE: Certain words and phrases identified by quotation marks (“) are typically found in the Definitions section of a policy.

A. “Insurance Transaction”

1. Selling
2. Soliciting
3. Negotiation
4. Effectuation of a Contract of Insurance
   a. Solicitation or inducement to purchase insurance

b. Preliminary negotiations towards the sale of insurance
c. Effectuation of a contract of insurance
d. Transaction of matters subsequent to effectuation of a contract of insurance and arising out of it

B. "Certificate of Authority"

1. Issued to a Company, Carrier, Insurer, or Insurance Company
   a. Not issued to a producer or agent
   b. Not issued to an agency or entity
2. No person may act as an insurer, directly or indirectly, unless authorized by the Office and issued a "Certificate of Authority"
3. **Violation of this rule is considered a felony of the 3rd degree**

C. "Authorized Company" and "Unauthorized Company"

1. Also known as "Admitted Company" and "Non-Admitted Company" respectively.
2. Authorized/Admitted
   a. Company is duly authorized to transact insurance business in the State of Florida
   b. Must have a Certificate of Authority
3. Unauthorized/Non-Admitted
   a. Company is not authorized to transact insurance business in the State of Florida
   b. Does not have a Certificate of Authority

D. "Unlicensed Entities"

1. No person may directly or indirectly act as an agent for any company not authorized to transact insurance business in the State of Florida.
2. **IGNORANCE IS NO EXCUSE**
   a. If an unauthorized insurance company fails to pay in part or full any claim or loss, and that party knew, or reasonably should have known that the contract was entered in violation of the insurance code, that insurer is liable to the insured for the full amount of the claim or loss not paid,
3. Mail Order Insurance Company
   a. Operates principally by mail without personal agent solicitation of prospects
   b. **Florida law prohibits unauthorized mail order companies from soliciting in Florida.** The transaction of insurance, including the application for insurance, must be taken by and the policy delivered though a licensed and appointed Florida agent.

E. Penalties for Violation

1. **Any agent licensed in Florida who knowingly represents or aids an "unauthorized company" commits a felony of the 3rd degree.**
2. Other penalties may be rendered based on the violation

VI. Licensing

A. Purpose

1. Provide protection to the general public by requiring minimum levels of insurance knowledge and competence to those licensed to sell, solicit, negotiate, and effect contracts of insurance.
2. Insurance licensees are expected to have an understanding of Florida insurance statutes and regulations.

B. License Types

1. Agent (Includes) **[Sec. 626.015]**
   a. General Lines Agent
   b. Life Agent
   c. Health Agent

d. Title Agent
2. Agent (Does not include)
   a. Customer Service Representative (CSR)
   b. Limited Customer Representative
   c. Service Representative
3. Public Adjuster
   a. Any person, who receives compensation, that acts on behalf of, or aids, an insured or 3rd party claimant in negotiation or effecting the settlement of claims for a loss covered by an insurance contract.
   b. Does not include a licensed attorney exempt under Florida law who, for compensation, prepares, completes, or files an insurance claim form for an individual or 3rd party.
   c. Does not include a licensed health insurance agent who assists an insured with coverage, billing, or claims processing issues
4. All-Lines Adjuster
   a. Self Employed, Employed by an insurance company, or independent adjusting firm
   b. Works on behalf of an insurer to determine the amount of a claim, loss, or damage payable as a result of an insurance claim.
5. Insurance Agency
   a. A location where a licensed insurance business entity engages in activities
   b. The term "Agency" does not include an insurer or an adjuster
   c. "Agency" must have an agency license, for each physical place of business, in order to transact insurance business. **[Sec. 626.015, .112]**
6. Unaffiliated Agent
   a. Licensed as an agent
   b. Not Appointed by or affiliated with any company
   c. Self-appointed
   d. Acts as an independent consultant (for a fee)
      i. Analyzing specific policies
      ii. Provide insurance advise or counseling
      iii. Make specific recommendation or comparisons
   e. Prohibited from being affiliated with an insurer, insurer-appointed insurance agent, or insurance agency contracted with or employing insurance company appointed agents.
   f. Can receive commissions on previous sales made prior to the date of appointment as an "unaffiliated insurance agent"
   g. Must be disclosed to client when making recommendations
   h. Unaffiliated Agents will pay the same appointment fees required of agents appointed by companies [Sec 626.015(18)]
   i. Does not include a Limited Lines Agent

C. Appointments

1. No agent may act as an insurance agent unless they are currently licensed by the Department and appointed by an insurance company, or other appropriate appointing entity.
2. Unaffiliated Agents
   a. Must appoint themselves
   b. Cannot be appointed by an insurance company
3. Time Frame
   a. Any producer who fails to maintain an appointment with an appointing entity during any 4 year (48 month) period, will not be granted an appointment by the Department until must qualify as if they were a first-time applicant. **[Sec. 626.112, .311, .381, .431, .471, .511, Rule 69B-211.004]**

D. Term of Appointment [Rule 69B-221.004]

1. New Appointment / Continued for Natural Persons
   a. Effectuated in a licensee's birth month
      i. Expires 24 month later on the last day of the licensee's birth month
2. Entities other than natural persons/ New Appointment or appointments being continued
   a. Effectuated in the same month a licensee was first licensed as an insurance representative
   b. Expires 24 months later on the last day of the licensee's license issue month
3. New Appointments / Any month other than the licensee's birth month
   a. Not valid for less than 24 months and no longer than 36 months
   b. Minimum and maximum numbers are used to convert the licensee's expiration date to the licenses birth month or issue month

E. Appointment Termination

1. Within 60 days' advanced written notice
   a. Appointees may terminate their appointment
2. Within 30 days after terminating the appointment
   a. Appointing entity must file written notice with the Department
      i. Include reasons and facts for termination **[Sec. 626.471, .511]**

F. License Requirements

1. Written Application (completed under oath and sign by the applicant)
   a. Full name
   b. Age
   c. Social Security Number
   d. Residence Address
   e. Business Address
   f. Mailing Address
   g. Contact Phone Numbers
   h. E-Mail Address
2. Meet required qualifications
   a. Proof of completion of required Pre-licensing Education
3. Payment of Fees

G. Pre-licensing Education

1. Life agents (2-14)
   a. The following does not apply to candidates that have a Chartered Life Underwriter® (CLU®) designation.
   b. Complete 40 hours of coursework in:
      i. Life insurance
      ii. Annuities
      iii. Variable Contracts
      iv. 3 hours of ethics
      v. instruction on unauthorized entities engaging in the business of insurance.
2. Health agents (2-40)
   a. The following does not apply to candidates that have a Chartered Life Underwriter® (CLU®) designation.
   b. Completed a minimum of 40 hours of approved coursework in multiple areas of insurance
      i. Health insurance
      ii. 3 hours of ethics
      iii. instruction on unauthorized entities engaging in the business of insurance to include:
         (1) Florida Nonprofit Multiple-Employer Welfare Arrangement Act (MEWA)
         (2) Employee Retirement Income Security Act (ERISA)
3. Health, Life & Variable Contract Agents (2-15)

a. The following does not apply to candidates that have a Chartered Life Underwriter® (CLU®) designation.
b. Complete a minimum of 60 hours of approved coursework in:
    i. Life insurance
    ii. Annuities
    iii. Variable Contracts
    iv. Health Insurance
    v. instruction on unauthorized entities engaging in the business of insurance to include:
        (1) Florida Nonprofit Multiple-Employer Welfare Arrangement Act (MEWA)
        (2) Employee Retirement Income Security Act (ERISA)

NOTE: *An applicant for life and health insurance license (2-15) only needs to complete 60 hours of pre-licensing education instead of having to meet the 40-hour requirements for both life agent and health agent.*

H. Background Check

1. The Department may investigate each and every applicant
2. Methods of investigation/background check
    a. Application
    b. Additional questions
    c. Fingerprints
    d. Other means as deemed necessary

I. Credit and Character Report of Applicants

1. Applies to 1st time applicants applying and qualifying for a license
    a. Appointment carrier or agent will secure and keep on file a full detailed credit and character report made by an established and reputable independent reporting service.

J. License Examination

1. Applicant must pass an examination that will test the applicants ability, competence, and knowledge
2. The exam material will cover responsibilities and duties of a Florida licensee
3. Within 30 days after passing the state licensing exam the Department will notify the applicant and issue the producer license
4. Passing grade on the state licensing exam is 70% and is valid for a period of 12 months
5. Department will not issue a license to an applicant based on test results that were earned greater than twelve months prior to an application for licensure
6. State licensing examination is **NOT** required for
    a. Applicant for renewal license, unless the Department determines that an examination is required to establish competence and or trustworthiness
    b. Applicant for a limited license
        i. Travel Insurance
        ii. Motor Vehicle Rental Insurance
        iii. Credit Insurance
        iv. In-Transit & Storage Personal Property
        v. Portable electronics insurance
    c. Reinstatement of a license or appointment as an agent whose license has been suspended within the 48 months prior to the date of application or written request for reinstatement
    d. An applicant for a 'Temporary License'
    e. An applicant who has been conferred the designation of Chartered Life Underwriter® (CLU®) or Chartered Property Casualty Underwriter® (CPCU®)

i. An applicant may be required to take an exam regarding Florida insurance laws and regulations)

f. An applicant applying for a non-resident license who holds a 'comparable' license in another state with similar examination requirements as Florida.

g. Degree from an accredited institution of higher learning approved by the Department; applicant may be required to take an exam regarding Florida insurance laws and regulations.

i. General Lines Agent or All-Lines Adjuster

(1) Qualifying degree must indicate a minimum of 18 credit hours of insurance instruction in the areas of

(a) Property
(b) Casualty
(c) Health
(d) Commercial insurance

ii. Life Agent

(1) Qualifying degree must indicate a minimum of 9 credit hours of insurance instruction in the areas of

(a) Life insurance
(b) Annuities
(c) Variable insurance products

iii. Health Agent

(1) Qualifying degree must indicate a minimum of 18 credit hours of insurance instruction in the areas of

(a) Health insurance products

K. Retaking the examination [Sec. 626.281]

1. An applicant who does not earn a passing score on the state examination may make additional attempts (Fees Apply)
2. Applicants may not take an examination for a license type more than five (5) times in a 12 month period

L. Maintaining a license

1. Continuing Education
   a. 24 Hours of approved Continuing Education (CE) every two (2) years
   b. CE Credits must include
      i. 5 Hours Law & Ethics Update
         (1) Every two years
         (2) Specific to the license held by the licensee
            (a) Multiple Authorities
               (i) Complete an update course that is specific to at least one of the licenses held.
               (ii) Material must include subject areas
               (iii) Insurance law updates
               (iv) Ethics for insurance professionals
               (v) Disciplinary trends and case studies
               (vi) Industry trends
               (vii) Premium Discounts
               (viii) Suitability of Products and Services
               (ix) Other topics as deemed necessary by the Department
      ii. 19 Hours of Elective CE
         (1) Exceptions to the 19 Hours of Elective CE
            (a) Licensed for 6 or more years
            (b) Must complete a minimum of 15 hours every 24 months

(c) Licensed for 25 years, CLU® or CPCU®, Bachelor's degree in Risk Management form an accredited college or university
(d) Must complete a minimum of five (5) hours of elective CE courses every 24 months
(e) Licensed CSR, Limited CSR, Title Agent, Motor Vehicle Physical Damage or Mechanical Breakdown insurance agent, or an industrial fire insurance or burglary insurance agent and who is not a licensed life or health agent, must complete a minimum of five (5) hours of CE courses every 24 months
(f) Bail bonds agent must complete the 5 hour update course and a minimum of nine hours of elective CE courses every 24 months

iii. Active Duty in the Military
(1) Written request for Waiver to the Department
iv. Excess Hours
(1) Hours that exceed compliance requirements during any two (2) year licensing period may be carried forward to the next licensing period
(2) Non-Resident Licensees
(3) Must meet their home state requirements
(4) Home state must be recognized by Florida reciprocity

2. Communicating with the Department **[Sec. 20.121]**
a. Insurers have twenty (20) days to respond to the Department once a consumer complaint has been filed
3. Recordkeeping
a. Notify the Department within 30 days after
i. Change of name
ii. Change of address
iii. Change of principal business street address
iv. Change of mailing address
v. Change of contract telephone numbers, including business telephone number
vi. Change of E-Mail address
(1) Personal
(2) Company
vii. Licensee has moved their principal place of residence or business will have their license and all appointments immediately terminated by the Department
viii. Failure to notify Department within the allotted time frame of 30 days **[Sec 626.551]**
(1) 1st Offense: Fine up to $250 and
(2) 2nd or Subsequent Offense: Fine of at least $500 or suspension or revocation
4. Administrative action **[Sec 626.536]**
a. Must notify the Department within 30 days after the final disposition of an administrative action taken against a licensee
b. Must submit a copy of the order, consent to order, or other relevant legal documents
5. Criminal Action **[Sec 626.621]**
a. Licensee must report, in writing to the Department, within 30 days
i. For any of the following events
(1) Plead guilty or "nolo contendre" to
(2) Convicted
(3) Found guilty of a felony or crime punishable by imprisonment of 12 months or more under any state, federal, or other country law.
b. Written report is required whether or not the agent was convicted by the court having jurisdiction of the case **[Sec 626.621]**
6. Agent's additional appointments
a. Upon receipt of appointment application and payment of fees, the Department may issue an additional appointment

b. No commissions may be paid by any company to the agent until the additional appointment has been conferred by the Department **[Sec 626.341]**

7. "Excess Business"/"Rejected Business" **[Sec. 626.793, .837]**
   a. An agent is permitted to place business with another company if the agent's own insurer rejects the applicant or if the amount is in excess of that which the agent's own company will write.
   b. No additional appointment is necessary
   c. Commissions can be paid ("Single Case Agreement")
   d. Governed by Florida's 'Exchange of Business Law'
8. Insurance agency licensing
   a. An insurance agency license is not required for a(n):
      i. Insurance entity owned and operated by a single licensed agent doing business in their own name, and does not employ or use other licensees
      ii. Branch office if it transacts business under the name and federal tax identification number as the licensed primary agency and has a designated agent in charge of the branch
   b. Agency licenses remains in force until
      i. Revoked
      ii. Cancelled
      iii. Suspended
      iv. Terminated by the Department
      v. Expires by operation of law
      vi. 3rd Party Completion
         (1) Florida law allows an agency to permit a 3rd party to complete, submit and sign a licensing application on behalf of the agency.
         (2) Agency is responsible for ensuring the application is true and accurate
         (3) Agency is held accountable for misstatements or misrepresentations
   c. Agency Application; must include **[Sec 626.172, .311]**
      i. Name of each
         (1) Owner
         (2) Partner
         (3) Officer
         (4) Director
         (5) Treasurer
         (6) LLC Member
         (7) who directs or participates in the management or control of the insurance entity
      ii. Street and email address of
         (1) Agency
         (2) Branch office(s)
         (3) Name of the agent in full-time charge of the agency and branch locations
   d. Branch Office
      i. Agent in Charge may be the same person who is in charge at the primary location.
      ii. Unlicensed employees shall not engage in insurance activities requiring licensure as an insurance agent or customer representative
   e. Filing with the Department
      i. Name and license number of the agent in charge at each location
         (1) Agent in charge can be changed at the option of the agency
         (2) Change is effective upon notification to the Department
         (3) Must be provided within 30 days after change
      ii. Physical address of each location

M. Prohibited practices

1. Temporary Suspension of agent license upon felony charge
   a. Department can temporarily suspend the license of an agent charged with a felony. The suspension shall continue if the licensee is convicted or if adjudication of guilt is withheld **[Sec. 626.611]**
2. Denial, suspension, revocation, or refusal to renew or continue license or appointment
   a. Department may deny an application if it finds that the applicant, licensee, or appointee has engaged in any of the following
      i. Violation of any provision of the insurance code
      ii. Violation of any lawful order or rule of the Department, Commission or Office
      iii. Failure to pay to any company any money belonging to them
      iv. Violation of the provision of twisting
      v. Engage in an unfair method of competition or unfair or deceptive act or practice
      vi. Willfully over insure any property or health risk
      vii. Have been found guilty of, pleaded guilty or nolo contendre to a felony or crime
      viii. Violation of the NAIFA Code of Ethics (Life Agent)
      ix. Cheating on an examination
         (1) Pre-Licensing
         (2) State Exam
      x. Fail to notify the Department, in writing, within 30 days after pleading guilty or nolo contendre to, or being convicted or found guilty of any felony or crime
      xi. Knowingly participate in an act which is in the violation of the insurance code or any other rule of the Department, Commission, or Office
      xii. Failure to comply with any civil, criminal, or administrative action taken by the child support enforcement program **[Sec. 626.621]**

VII. Agent Responsibility

A. "Fiduciary Capacity"

1. Person in a position of a special trust and confidence.
2. All monies belonging to an insurance company are trust funds received by the licensee in a fiduciary capacity
3. Agent must keep funds belonging to each company for which an agent is not appointed (other than surplus lines) in a separate account so that the Department or Office may properly audit such accounts
4. Licensee must keep and make available all books, accounts, and records
5. Every licensee shall preserve books, accounts, and records pertaining to a premium payment for at least 36 months after payment
   a. 3-year requirement does not apply to insurance binders when no policy is ultimately issued and no premium is collected
6. Fines and penalties for misappropriated or diverted fiduciary funds
   a. If $300 or less; misdemeanor of the 1st degree.
   b. If $300 or more but less than $20,000; felony of the 3rd degree
   c. If $20,000 or more but less than $100,000; felony of the 2nd degree
   d. If $100,000 or more; felony of the 1st degree

B. Compensation

1. Florida law specifies that no policy of life or health insurance may be issued for delivery in this state unless the application is taken by, and the policy delivered through, a licensed agent who will receive the usual commission
2. No person other than a licensed and appointed agent may accept any commission or other valuable compensation for soliciting or negotiating insurance
3. Commission for examining any group health insurance **[Sec. 626.593]**

a. Health agents can charge a fee for both individual and group health insurance.
b. Written contract between the agent and party being charged is required.
c. Must clearly define that the consulting fee is separate and negotiated.
d. Compensation is limited to
    i. Providing advice,
    ii. Providing counsel, or
    iii. Providing recommendations regarding any group health insurance or group health benefit plan
e. Commission Rebates
    i. If a commission is earned, it will be rebated to the contracting party within 30 days of receipt of the commission paid by the company to the agent

4. Commission rebates
    a. Agent/Agency may **NOT** rebate any portion of a commission except as follows
        i. Rebate shall be available to all insureds in the same actuarial class
        ii. Rebate shall be in accordance with rebating schedule filed with the insurer issuing the policy to which rebates apply
        iii. Rebate schedule shall be uniformly applied to all insureds who purchase the same policy through the agent, for the same amount of coverage, receive the same percentage rebate
        iv. Rebates shall not be given to an insured if the company prohibits its agents from rebating commissions
        v. Rebate schedule is displayed in public view in the agents office and available for the public's view at their request
        vi. The rebate available is not subject to discrimination based on an applicants' age, sex, place of residence, nationality, ethnic origin, marital status, occupation, or the location of risk
    b. Commissions Contingent on Loss Settlements (Rebates, Rebate Schedules, Collateral Business **[Sec. 626.572])**
        i. Agent/Agency must maintain copies of all rebate schedules for a period of at least 60 months, from their effective date
        ii. No rebate may be withheld or limited based on factors that are unfairly discriminatory
        iii. No rebate may be given if it is not reflected on the rebate schedule
        iv. No rebate may be refused or granted based upon the purchase, or failure of the insured or applicant, to purchase collateral business

C. Ethics

1. Scope
    a. All agents of all insurers have a common obligation to work together in serving the best interest of the insuring public.
    b. Methods of achieving this
        i. Understanding and observing the laws governing life insurance
        ii. Presenting accurately and completely every facts essential to a client's decisions
        iii. Fair in all relations with colleagues and competitors
        iv. Always placing the policyholder's interests first **[Rule 69B-215.210, F.A.C.]**
2. Use of Designations
    a. Purpose
        i. To protect consumers from dishonest, deceptive, misleading, and fraudulent trade practices with regards to the use of certification and professional designation in the selling, soliciting, negotiating, and effecting of contracts
    b. The Department, Commission, or Office does not endorse any professional designation
    c. Definitions
        i. "Designation"

(1) Any combination of words, any acronyms standing for a combination of words, or job title that implies or indicated a special level of knowledge or training.
(2) A designation may not be lawfully used under the Insurance Code unless it is obtained from an organization that has published standards and procedures for assuring the competency of its certificants or designees on specific subject matters

ii. "Certification"
(1) Any designation that indicates, implies, or recognizes that an individual or organization meets certain established criteria beyond the basic level required for the license held

iii. Prohibited uses of a designation include (not limited to)
iv. Use by a person who has not actually earned or is ineligible to use such designation
v. Use of a self-conferred or non-existent designation
vi. Use that indicates or implies a level of occupational qualification obtained through training, experience, or education that the person utilizing the designation does not actually have
vii. Use of any designation not obtained in compliance of Florida law
viii. Uses that violate the NAIFA Code of Ethics
(1) See page 426 for sample
(2) **[Rule 69B-215.236, F.A.C.]**

VIII. Insurance Guaranty Fund (State Funded)

A. Florida Life and Health Insurance Guaranty Association is a non-profit legal entity

B. All life, health and annuity companies are members of the Association as a condition of their authority to transact insurance business in the State of Florida

C. Purpose of the Association

1. To protect policyowners, insureds, beneficiaries, annuitants, payees, and assignees of insurance policies and contracts against the failure of a company to perform its contractual obligations due to its impairment or insolvency **[Sec. 631.711-.735]**

D. Scope of Provisions

1. Coverage will be provided to residents of Florida and to residents of other states only if
   a. Insurance company that issues the policy or contract is domiciled in Florida
   b. Other states have guaranty associations that are similar to that of Florida
   c. Persons are not eligible for coverage by such associations
2. Association coverage does not apply to
   a. Portion or part of a variable contract (life or annuity) not guaranteed by an insurance company
   b. Portion or part of any policy or contract under which the risk is borne by the policyholder
   c. Fraternal benefit societies as defined in **§ 632.601**
   d. Health Maintenance Insurance
   e. Dental service plan insurance
   f. Pharmaceutical service plan insurance
   g. Optometric service plan insurance
   h. Ambulance service association insurance
   i. Funeral (preneed) merchandise or service contract insurance
   j. Pre-paid health clinic insurance
   k. Annuity contract not issued to and owned by an individual
   l. Portion of a policy that exceeds association limitsContract or policy providing

i. Medicare Part C (Medicare Advantage Plan)
ii. Medicare Part D (Medicare Prescription coverage)

m. Policy or contract assumed by the impaired or insolvent insurance company under a contract of reinsurance

E. Definitions

1. "Impaired Insurer"
   a. A member company deemed by the Department to be potentially unable to fulfill their contractual obligations and not an insolvent company
2. "Insolvent Insurer"
   a. Member insurance company authorized to transact insurance in this state and against which an order of liquidation, with a finding of insolvency, has been entered by a court of competent jurisdiction

F. Establishment of association; separate accounts

1. Purpose of administration and assessment is to maintain three (3) accounts
   a. Health insurance account
   b. Life insurance account
   c. Annuity account

G. Board of Directors

1. Consists of not fewer than five (5) nor more than nine (9) member insurance companies.
2. One member of the board must be a "domestic insurer"
3. Members may be reimbursed for expenses incurred by them as members of the board of director, but not otherwise compensated for their services

H. Powers and duties of association

1. Aggregate liability of the association shall not exceed
   a. Life; $100,000 in net cash surrender and net cash withdrawal values
   b. Annuity; $250,000 in net cash surrender and net cash withdrawal values
   c. Cash Value; $300,000 in benefits with respect to one life
   d. The association shall not be liable for any penalties or interest

I. Assessments against member companies

1. The funds necessary to carry out the powers of the association are the totals of all assessments upon a member company for each account of insurance.
2. The total of all assessments for each member insurer may not, in any 12 month period, exceed one percent (1%) of the sum of the insurance company's premiums written in this state, regarding business covered by the account received during the three (3) years preceding the year in which the assessment is made, divided by three (3)

J. Powers and duties of the Department

1. Domestic Insurer; the Department shall be appointed as the liquidator or rehabilitator
2. Foreign or Alien Insurer; the Department shall be appointed as conservator
3. The Office may suspend or revoke a Certificate of Authority if after a notice and hearing, the insurer fails to comply with the approval plan or fails to pay an assessment

K. Use of membership in advertising

1. A person may not make, publish, circulate, disseminate, or place before the public any advertisement that uses the existence of the Florida Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Association

IX. Marketing Practices

A. Unfair methods of competition [Sec. 626.9541]

1. The following are defined as unfair methods of competition and unfair or deceptive acts or practices
    a. Sliding
    b. Boycott, coercion, and intimidation
    c. Misrepresentations and false advertising of insurance policies
    d. Defamation
    e. False advertising
    f. Unfair discrimination
2. Sliding
    a. The practice of wrongfully indicating a product (ancillary coverage) is required by law in conjunction with the purchase of another product
    b. Representing that a specific ancillary coverage or product is included in the policy applied for without an additional premium charge, when such charge is required
    c. Charging an applicant for an ancillary product or coverage, without consent of the applicant, and indicating that the coverage is included in their premium
3. Boycott, coercion, and intimidation
    a. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in, or tending to result in, unreasonable restraint of, or monopoly in, the business of insurance
4. Misrepresentations and false advertising of insurance policies
    a. Statements made by a licensee about a policy that states
        i. Inaccurate information pertaining to benefits, advantages, conditions, or terms of any insurance policy
        ii. Inaccurate information regarding dividends or shares of surplus to be received on any insurance policy
        iii. False or misleading statements as to the share of surplus previously paid on any insurance policy

        [Complete list located in State Study Manual]
5. Defamation
    a. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding and abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statements which is false, malicious, or derogatory to the financial condition of an insurance company
6. False advertising
    a. Knowingly making, publishing, disseminating, circulating, or placing before the public any representations, assertion, or statement with respect to the business of insurance that is untrue, deceptive, or misleading
7. Unfair discrimination
    a. Insurers may not discriminate based on race, color, creed, marital status, sex or national origin
    b. No company authorized to transact insurance in the State of Florida shall refuse to issue, nor charge a higher premium on a life or health insurance policy solely because the person to be insured has the sickle-cell trait. **[Sec. 626.9706]**
8. Other unfair practices
    a. False statements and entries
        i. Includes the know filing of any false material statement, false entry or the omission of a material fact in any book, report, or statement
    b. Failure to maintain compliant-handling procedures
        i. The failure of any person to maintain a complete record of all complaints received for a period of audit to audit
        ii. A complaint is defined as any written communication expressing a grievance

c. Advertising gifts permitted
    i. For the purpose of advertising, an agent, insurance company may give to a prospective insured, insured, or other person any article of merchandise having a value not more than $25
d. Life insurance limitations based on past foreign travel experiences or future foreign travel plans
    i. A insurer cannot refuse the issuance of a life policy solely on an applicant's response to questions pertaining to their past or future foreign lawful travel experiences; unless it is actuarially supported
e. Loan or extension of credit; voluntary selection of insurer **[Sec. 626.9551]**
    i. No lender may require, as a condition to lending money or extension of credit, that the applicant purchase a policy through a particular insurance company, agent, or broker

9. Unfair claims practices
    a. 3 Parts
        i. Attempting to settle claims on the basis of an application, or any other material documents that was altered without knowledge or consent of, the insured
        ii. Material misrepresentation made to an insured, or any other person having an interest in the proceeds payable under a contract or policy, for the purpose of effecting settlement of such claims on a less favorable term than those provided in the contract
        iii. Committing or performing, with such frequency as to indicated a general business practice, any of the following:
            (1) Failure to adopt and implement standards for the proper investigation of claims
            (2) Misrepresent pertinent or material facts relating to policy coverages
            (3) Misrepresenting insurance policy provisions relating to coverage issues
            (4) Failure to acknowledge and communicate promptly with respect to claims
            (5) Deny claims without conducting proper investigations based on information provided
            (6) Failure to respond to an insured written request, within 30 days after a proof of loss has been completed, to affirm or deny the full or partial coverage of a claim
            (7) Failure to provide, in writing, a reasonable explanation as to why a claim has been denied or the offer of a compromise settlement
            (8) Failure to notify the insured of any additional information necessary for the processing of a claim
10. Fraud
    a. Intentionally concealing a fact of material substance for the purpose of misleading another is a fraudulent act
    b. A person commits a fraudulent insurance act if that person knowingly submits a statement that contains false information for the purpose of defrauding an insurer, broker, or agent
11. Fraudulent signatures on an application or policy-related document
    a. The willful submitting to an insurance company, on behalf of a consumer, an insurance application or policy-related document bearing a false or fraudulent signature
12. Proof of loss; fraud statement **[§817.234 ,Sec. 626.8797]**
    a. All proof of loss statements must prominently display the following statement
        i. "Pursuant **§817.234**, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or caused to be presented a proof of loss or estimate of coast or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree"

13. Controlled business **[Sec. 626.784, .830]**
    a. The Department will not issue a license, or an appointment, to any life or health agent that obtains their license for the purpose of soliciting, negotiating, or procuring controlled business.
        i. Definition
            (1) Life or health insurance or annuity contracts covering the agent, or family members; officers, directors, stockholders, partners, or employees of a business in which the agent or a family member is engaged; or the debtors of a firm, association, or corporation of which the agent is an officer, director, stockholder, partner, or employee
        ii. Violation; controlled business
            (1) A violation exists if the Department finds that during a 1 year period the premiums submitted on controlled business are in excess of the premiums submitted, during the same period, by the licensee on life and health insurance contracts to the general public
14. Twisting
        i. Knowingly making misleading statements for the purpose of inducing any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, convert, or take out another insurance policy with another carrier, to which actions are to the detriment of an insurance applicant or policy holder
15. Churning
    a. Practice where values in an existing insurance policy or annuity contract are directly or indirectly used to purchase another policy from the same carrier for the purpose of earning additional premiums, fees, commissions, or other compensation or consideration
        i. Without a reasonable basis for such replacement
            (1) Must show a benefit to the policyholder
        ii. The replacement must not be fraudulent, deceptive, or otherwise misleading
        iii. When the applicant is not informed that the policy values of the existing policy or contract will be reduced, forfeited, or used in the purchase of replacing or purchasing an additional policy or contract
        iv. Without informing the applicant that the replacing or additional policy will not be paid-up or that additional premiums will be due **[FAC Rule 69B-151.202]**
16. Unlawful/Lawful rebates
    a. It is unlawful to provide a rebate
        i. Other than plainly expressed in the contract
    b. The following are not considered unfair discrimination or unlawful rebates (providing such is fair and equitable to all policyholders)
        i. Paying bonuses to all policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from non-participating insurance
        ii. Issued on the industrial debit plan and for which the policyholder, for a specified period of time, has made premium payments directly to an office of an insurance company in the amount that fairly represents the saving in collection expense
        iii. The readjustment of the premium rate for a group insurance policy based on the loss or expense thereof, which may be retroactive only for such policy year

B. General prohibition and penalties

1. Fines pertaining to unfair methods of competition **[Sec. 626.9521]**
    a. Any person who engages in an unfair method of competition is subject to a fine in an amount not greater than $20,000 for each willful violation
        i. Aggregate Fine

(1) Non-Willful Violation
(a) An aggregate fine, not to exceed $10,000 for violations arising out of the same action
(2) Willful violation
(a) An aggregate fine, not to exceed $100,000 for violations arising out of the same action

2. Fines pertaining to “twisting” or “churning”
a. Misdemeanor of the first (1st) degree
b. Punishable as stated in the Florida criminal code
c. Administrative fine not greater than $5,000 for each non-willful violation
d. Administrative fine not greater than $75,000 for each willful violation
i. To impose an administrative fine, a violation involving “twisting” or “churning” must exist
3. Fines pertaining to fraudulent signatures
a. If a person willfully submits fraudulent signatures on an application or policy document, the person commits a felony of the third (3rd) degree, punishable as stated in the Florida criminal code
b. Administrative fine not greater than $5,000 for each non-willful violation
c. Administrative fine not greater than $75,000 for each willful violation
4. Aggregate administrative fines for “twisting”, “churning” and fraudulent signatures
a. Aggregate fine
i. Non-Willful violation
(1) An aggregate fine, not to exceed $50,000 for violations arising out of the same action
ii. Willful violation
(1) An aggregate fine, not to exceed $250,000 for violations arising out of the same action
5. Hearings and cease and desist orders (CDO) **[Sec. 626.9561, .9571, .9581, .9601]**
a. Both the Department and Office shall have each have powers within their respective regulatory jurisdiction to examine and investigate the affairs of every person involved in the business of insurance in order to determine if such person has been or is engaged in any unfair method of competition or unfair or deceptive act or practice
b. The Department and Office both may conduct a hearing pertaining a CDO
i. After a hearing, the Department or Office shall enter a final order in accordance to Florida law
(1) If it is determined that a person has engaged in an unfair or deceptive act, the Department or Office will issue an order to the violator ordering the ‘cease and desist’ of such method
(2) Any person who violates a CDO may be subject to one or more of the following violations
(a) Monetary penalty not to exceed $50,000
(b) Suspension or revocation of persons’, entities’, or insurers’, certificate of authority, license, or eligibility to hold such

X. Life Insurance, Annuity Contracts, and Health Insurance Advertising

A. Purpose [FAC Rule 69O-150.001, .003, .101, .103]

1. Provide prospective purchasers with clear and unambiguous statements in the advertisement of life and health insurance and or annuity contracts
2. This purpose is accomplished by guidelines and standards of conduct in advertising to ensure that product descriptions are presented in a manner that prevents unfair, misleading, and deceptive advertising
3. Advertisement includes any method of communication
a. In a publication, such as a magazine or newspaper

b. In the form a letter, poster, pamphlet, notice or circular
c. Over any airways, including radio, television, or other form of data transmission
d. Advertisement does not include
    i. Material to be used solely for the training and education of an insurance company employee, agent or broker
    ii. Internal communication within an insurer's own organization not intended for dissemination to the public
    iii. Individual communication with a current policyholder regarding existing coverage other than material urging the policyholder to make changes to their coverage
    iv. Communication between a prospective group or blanket policyholder and an insurance company in the course of selling, soliciting, or negotiation a contract

B. Method of dissemination and form of content of advertisement

1. All disclosures must not be **[FAC Rule 69O-150.004]**
    a. Minimized
    b. Rendered obscure
    c. Or presented in an ambiguous fashion in order to confuse or mislead an applicant or policyholder
2. All advertisements must be clear and complete in order to avoid deception or the capacity to mislead or deceive
3. An insurer must clearly identify its life insurance, annuity contract, and health insurance as an insurance policy or annuity contract in its advertisement
4. The name of any policy must be followed by or include the words "Insurance Policy", "Annuity" , or similar words clearly identifying the fact that an insurance policy or annuity is being offered
    a. Examples
        i. Whole life insurance policy (WL)
        ii. Level term life insurance
        iii. Long-Term Care Insurance Policy (LTCi)
        iv. Deferred annuity
        v. Major medical insurance policy
        vi. Disability insurance policy (DI)
5. Advertisements of benefits or proceeds payable or premiums payable **[FAC Rule 69O-150.006, .107]**
    a. No advertisement may omit phrases, words, statements, references, etc. if such omissions will have the capacity to mislead purchases as to the nature and extent of the policy benefits, loss covered, and premiums payable
6. Testimonials; disparaging comparisons and statements; identity and statements about the insurer
    a. Testimonials **[FAC Rule 69O-150.001, .112]**
        i. Endorsements must be genuine
        ii. Represent the current opinion of the author
        iii. Be applicable to the policy advertisement
        iv. Accurately reproduced
    b. Disparaging comparisons and statements
        i. An advertisement must not make an unfair or incomplete comparison of policies, benefits, or contracts
    c. Identity of insurer
        i. The name of the actual insurance company must be stated in all carrier advertisements
        ii. Form number(s) of the policy must be stated
        iii. An advertisement must not use a trade name, slogan, symbol that would be misleading as to the true identity of the actual insurer

iv. No advertisement may use symbols, words, or combination thereof used by Federal, State government agencies if such use is to tends to confuse or mislead the prospective insured into believing that the solicitation is in some manner connected with such agency
v. All advertisements used by agents, producers, brokers, or solicitors of an insurer, must have prior written approval or prior oral approval with subsequent written confirmation of approval by the insurer **[FAC Rule 69O-150.113, .114]**

7. Advertising file **[FAC Rule 69O-150.018, .119]**
   a. Each insurance company must maintain either its home or principal office a complete file containing
      i. Every printed, published, or prepared advertisement of its individual policies
      ii. Typical printed, published, or prepared advertisements of its blanket, franchise, and group policies
      iii. A notation must be attached to each advertisement indicating the manner and extent of distribution and the form number of any policy advertised
      iv. The file must specifically include those advertisements submitted to the insurance carrier by agents, brokers, or others and approved the insurer for use in Florida
      v. The file must be available for inspection by the Office
   b. All advertisements must be maintained in the file for a period of **4 years (48 months)** or until the filing of the next regular report or examination by the carrier; whichever is longer

QUESTIONS IN TEXT BOOK = 20

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UNIT

27 FLORIDA LAWS AND RULES PERTINENT TO LIFE INSURANCE

OVERVIEW

This unit outlines only those marketing practices, policies, and provisions for life insurance that are regulated by the state of Florida. Candidates for the Life Insurance Examination will be tested on their knowledge of the various required laws, rules, and regulations that are covered in this unit.

OBJECTIVES

After completing this chapter, you should be able to understand:

- Marketing Practices
- Policy Replacement
- Individual Contracts
- Group Life
- Annuities

KEY TERMS

Annuity Suitability
Buyer's Guide
Florida Replacement Rule
Group Conversion Rights
Group Life Insurance
Lapse Notification and Additional Addresses
Other Policy Provisions
Policy Assignment
Policy Conversion
Policy Summary

QUESTIONS IN STATE STUDY MANUAL

25 (Twenty Five)

I. Marketing Methods And Practices

A. Agent Responsibilities

1. Must inform the prospective buyer
   a. Before the presentation
      i. Full name of the insurer that is being represented
2. If using terms such as
   a. Financial planner
   b. Investment adviser
   c. Financial consultant
   d. Financial counselor

   Must **not** be used to imply that an insurance agent is engaged in an advisory business in which they receive compensation unrelated to the sale of a policy or contract; unless that is actually the situation
3. Dividends
   a. Any reference to a policy dividend must include a statement indicating that it is not guaranteed
4. Time value of money
   a. If a presentation or system does not recognize the 'time value of money' through the use of appropriate interest adjustments, must not be used for comparing the cost of two or more life insurance policies or contracts
5. Life insurance cost indexes
   a. Include an explanation to the effect that the indexes are useful only for the comparisons of the relative costs of two (2) or more similar policies
   b. A life insurance cost index that reflects dividends or an equivalent level annual dividend must be accompanied by a statement that it is based on the insurer's current dividend scale and is not guaranteed **[SEC 626.99]**

B. Disclosure [Sec. 626.99]

1. "Free Look Period"
   a. The company shall provide each prospective buyer a "Buyer's Guide" and "Policy Summary" prior to accepting the applicant's initial premium, unless the policy provides for an unconditional refund for at least 14 days
   b. If the policy does have a 14 day "Free Look Period" then a "Buyer's Guide" and "Policy Summary" must be delivered either with the policy or before delivery of the policy
2. Buyers Guide
   a. Purpose
      i. To improve the buyers understanding of the basic features of the policy that has been or will be purchased
      ii. Improve the ability of the buyer to evaluate the relative costs of plans of similar types of insurance
      iii. Improve the buyer's ability to select the most appropriate plan of life insurance for their needs
3. Policy Summary
   a. A written statement explaining multiple components of a policy; including, but not limited to:
      i. Title: "STATEMENT OF POLICY COST AND BENEFIT INFORMATION"
      ii. Name and Address of insurance producer
      iii. Full name and home office address of the life insurer
      iv. Where applicable; clearly illustrated premium and benefit patterns
         (1) Life insurance cost indexes
            (a) Annual premium for the basic policy

(b) Annual premium for each optional rider
(c) Guaranteed amount payable upon death
(d) Cash dividends payable at the end of the year
(i) Values show separately for the basic policy and each rider
(ii) Dividends need not be displayed beyond the 20th policy year
(e) Effective policy loan annual percentage interest rate
(i) Include maximum percentage rate if applicable
(f) Life insurance cost indexes for 10 and 20 years
(i) No beyond the premium-paying period

v. Participating Policies
(1) Equivalent level annual dividend
(2) A statement that dividends are based on the insurance company's current dividend scale and are not guaranteed

vi. Date on which the Policy Summary is prepared

C. Advertising and Sales [Sec. 626.9531]

When selling, soliciting, or negotiating insurance products, agents must clearly indicate, to the prospective insured, that they are acting as insurance agents with regard to insurance products and identified insurers.

1. Disclosure requirements for indeterminate value life annuity contracts advertisements
   a. It is prohibited for an advertisement to contain a rate to be earned unless all limitations and conditions are disclosed to the policy holder, certificate holder, or annuitant.
   b. The disclosure shall include (if applicable)
      i. Premium expense
      ii. Administrative charge
      iii. Full surrender charger (year by year)
      iv. Market value adjustment
      v. Participation rates
      vi. Free withdrawal provisions or bail-outs
      vii. Guaranteed minimum interest rate during the accumulations period and the annuitization period
   c. An advertisement must not refer to an annuity as a CD annuity
2. All variable life and annuity advertisements shall disclose whether the insured may realize a positive or negative return on the principal, including potential loss of the original principal contribution **[FAC Rule 69O-150.106]**Advertisements of proceeds payable, premiums payable
   a. Invitations to contract must clearly reflect the following information
      i. Name of the insurer
      ii. Agent
      iii. Policy form number(s)
      iv. Type of plan
      v. Premium payable
      vi. Payment period
      vii. Changes in the face amounts and premiums (if applicable)
   b. Life insurance sold by a direct response shall not advertise with the phrase(s)
      i. "no salesman will call"
      ii. "no agent will call"
      iii. "by eliminating the agent and/or commission we can offer this low cost plan"
      iv. Wording similar or in a misleading manner
   c. Invitations to join an Association, Trust or Discretionary Group
      i. Must solicit insurance on an application that is separate and distinct and must include separate signatures for each application

ii. Membership fee or dues
(1) Disclosed on each application
(2) Appear separately on the application so that not confused with the premium amounts for insurance coverage

d. An advertisement must not refer to a premium as a “deposit”

3. Dividends
a. Advertisement cannot be misleading
b. Cannot, directly or indirectly, imply that the amount of a dividend or divisible surplus is guaranteed
c. Any comparison between participating and non-participating policies or contracts must be true and accurate [**FAC Rule 69O-150-109]**

II. Florida Replacement Rule

A. Purpose [FAC Rule 69B-151.001, .008; 69O-151.001, .008]

1. Regulate the activities of insurance carriers and agents with respect to the replacement of existing life insurance
2. Protect the interests of life insurance policy owners by establishing minimum standards of conduct to be observed in the replacement of existing life insurance.
a. This is accomplished by
i. Ensuring the policy owner receives information with which an informed decision can be made in their best interest
ii. Reducing the opportunity for misrepresentation or incomplete disclosures

B. Replacement

1. A transaction in which new life insurance is to be purchased
2. It is known to the proposing agent or company, that existing life insurance has been in force; or is to be
a. Lapsed, surrender, terminated, or forfeited
b. Converted to Reduced Paid-up, continued as extended term insurance, or otherwise reduced in value by the use of non-forfeiture benefits or other policy values
c. Amended to reflect a reduction in benefit coverage
d. Amended to reflect a reduction in term
e. Reissued with any reduction in cash value
f. Pledged as collateral or subjected to borrowing for an amount in aggregate exceeding 25% of the loan value set forth in the policy

C. Life Insurance (with regards to replacement includes)

1. Life insurance
2. Annuities
3. Tax-sheltered annuities
4. Life insurance policies that qualify under the definition of a tax-sheltered annuity

D. Exemptions (Replacement rules do not apply)

1. Industrial insurance
2. Group, franchise, individual credit life insurance
3. Group life and life policies issued in connection with
a. Pension
b. Profit sharing
c. Other benefit plan qualifying for tax deduction ability of premiums
4. Contractual change or conversion privilege of a policy or contract within an existing company
5. Variable life insurance or annuities under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account

E. Duties of agent

1. Each agent must submit with each application for coverage the following items
   a. Statement signed by the applicant(s) as to whether or not the new insurance will replace existing life insurance
   b. Statement signed by the agent(s) as to whether or not the agent knows if the insurance transaction will result in a replacement
2. Whether or not a replacement is being made, the agent(s) must do the following
   a. Leave with the applicant(s) a copy of all sales proposals used for the presentation of the applicant
   b. No later than the time of taking the application, have the applicant(s) sign a 'Notice of Applicant Regarding Replacement of Life Insurance' form
      i. A copy must be submitted to the replacing company
      ii. A copy must be given to the applicant
      iii. The form must be signed by both the applicant(s) and agent(s)

F. Duties of replacing company

1. Replacing insurance company must inform its field agents of the following requirements
   a. Require the agent to submit the following with an application for life insurance
      i. Notice to Applicant Regarding Replacement of Life Insurance
      ii. Copy of all sales proposals (used in the presentation)
   b. Send, when requested, a completed Comparative Information Form
      i. Must be submitted within five (5) working days, from the date of the application and the Notice to the Applicant Regarding Replacement of life Insurance, to the home or regional office
   c. Send to the existing insurance company a copy of the replacement notice to their home or regional office
   d. Provide each prospective purchaser a Buyer's Guide and a Policy Summary prior to accepting any initial premium or premium deposit, unless the policy contains a provision for an unconditional refund for a period of at least ten (10) days, in which the Buyer's Guide and Policy Summary must be delivered with the policy or prior to delivery of the policy. (**NOTE: Florida's 14-day Free Look meets this standard).**
   e. Maintain copies for a period of three (3) years
      i. Notice of Applicant Regarding Replacement of Life Insurance
      ii. Requested Comparative Information Forms
      iii. Sales proposals used
      iv. Replacement register, cross indexed by replacing agent and insurer

G. Surrender recommendation [Sec. 627.4553]

1. "Insurance agents that recommend the surrender of an annuity or life insurance policy containing a cash value and do not recommend that the proceeds from the surrender be used to fund or purchase another annuity or life insurance policy, before execution of the surrender, the agent must provide written information relating to the annuity or policy to be surrendered. Such information must include, but is not limited to:
   a. the amount of any estimated surrender charge
   b. the loss of any minimum interest rate guarantees
   c. the possibility of tax consequences
   d. the amount of any forfeited death benefit; and
   e. a description of any other investment performance guarantees being forfeited as a result of the transaction.
2. "Surrender" means "voluntary surrender, by the owner's request, of the annuity or life insurance policy before its maturity date, in exchange for the policy's current cash surrender value"

III. Individual Contracts

A. Standard provisions

1. Protection of beneficiaries from creditors **[Sec. 222.13, .14]**
   a. At the death of the insured, the insurer will pay the life insurance death benefit exclusively to the beneficiary(ies) designated in the contract
   b. Whenever the insurance is payable to the estate of the insured, the insurance proceeds will become a part of the insured's estate and will be administered in accordance to the probate laws of the state.
2. Proceeds exempt from attachment **[Sec. 222.14]**
   a. Cash surrender values issued upon the lives of citizens or residents of the State of Florida;
   b. Proceeds of annuity contracts issued to citizens or residents of the State of Florida

   Shall not be liable to attachment, garnishment, or legal process in favor of any creditor unless the insurance policy or annuity contract was effected for the benefit of such creditor
3. Prohibited provisions
   a. Policy loan **[Sec. 627.4585]**
      i. A fixed rate not to exceed 10% annual interest (subject to restrictions) is permissible for a policy loan
      ii. An Adjustable rate of interest, with limits based on the average monthly published interest rate determined by Moody's Corporate Bond Index
   b. Free Look **[Sec. 626.99]**
      i. Unconditional refund of premiums
      ii. Available for a period of at least 14 days
      iii. Fixed annuity contracts
         (1) Includes contract fees or charges
         (2) Available for a period of 21 days
         (3) Refund shall be equal to the cash surrender value provided in the annuity contract, plus any fees or charges deducted from the premiums or imposed under the contract; or a refund of all premiums paid
   c. Grace Period (individual) **[Sec. 627.453]**
      i. Not less than 30 days within which payment of any premiums may be made
      ii. If a policy becomes a claim, during the grace period and the premium due has not been paid, the amount owed may be deducted from the death benefit payment
   d. Designation of beneficiary
      i. The policy owner has the right, at all times unless a the beneficiary designation is name irrevocable, to change a beneficiary
   e. Life agents as beneficiaries **[Sec. 626.798]**
      i. A life insurance agent is not permitted to be named as a beneficiary of a life insurance policy covering the life of a person who is not a family member of the agent; unless the agent has an insurable interest in the life of such person
      ii. Insurable Interest is defined to include
         (1) Family member (father, mother, son, daughter, brother, sister, grandfather, grandmother, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half-brother, or half sister
   f. Effects of divorce on death proceeds **[Sec. 732.703]**
      i. A beneficiary designation naming a former spouse is void at the time the policyholder's marriage is judicially dissolved, so long as the beneficiary designation was made prior to the court order
   g. Additional lapse notice and secondary addressee

i. Life insurance contract, issued for delivery in Florida covering a person 64 years of age or older and has been in force for at least 12 months, may not be lapsed for non-payment of premiums unless, after the expiration of the grace period, and at least 21 days before the effective date of any impending lapse, a notification has been mailed to the policy owner and to a specified secondary addressee

B. Non-forfeiture options [Sec. 627.476]

1. Life insurance policies delivered in Florida must contain the following benefits
   a. Surrender Cash Value
   b. Reduced Paid-Up Life Insurance
   c. Extended Term Life Insurance

C. Policy settlement

1. When a policy becomes a claim, the contract indicates that the death benefit is to be paid according to the agreement in such contract.
2. When the policy provides for a payment of its proceeds in a lump sum, the payment must include interest from the date the insurance company received written proof of loss (death) of the insured.
3. If payments of death benefit proceeds are to be paid in installments, a table showing the amounts and periods of payments must be included in the policy

IV. Group Life

A. Group Life

1. Standard provision/Required provision
   a. Group life insurance policies **[Sec. 627.551, .558, .565]**
      i. FLORIDA LAW: No minimum number of members (subscribers, employees, lives) required for a group policy
2. Grace Period (Group)
   a. Grace period of 31 days.
   b. If the insured dies during the grace period, the death benefit will be paid
3. Incontestability
   a. A group life insurance policy shall provide that the validity of the policy shall not be contested, except for non-payment of premium, after it has been in force for 24 months from its date of issuance
4. Attachment of application to policy; representations in the application
   a. A copy of the application is attached to the back of the contract when the policy is issued.
   b. All statements made by the applicant that are believed to be true to the best of the applicant's ability, are considered to be representations
5. Misstatement of age
   a. A clearly stated provision stating that in the event an age is misstated in an application, a specific method of adjustment will be used
   b. Misstatement of age is not subject to the incontestability period
6. Individual Certificates
   a. A group life insurance carrier must issue to each member a certificate containing the following information
      i. Group number
      ii. Person insured
      iii. Insurance protection being provided
      iv. Whom the insurance benefits are payable to
      v. Dependent's coverage included
      vi. Rights and conditions
      vii. Person to whom the insurance benefits are payable

b. Alternative statement

"This certificate provides life insurance for the employees and dependents, if applicable, of (employer's name and address) under (group contract number). The employee shall be given a copy of the group enrollment application. The benefits are payable to the beneficiaries of record designated by the employee."

c. Notification of termination **[Sec. 627.5725]**
   i. Company shall notify each certificate holder when the master policy has expired or been cancelled.
   ii. The policy owner shall advise the certificate holder as soon as practicable upon notice of expiration or cancellation

B. Conversion rights

1. Conversion on termination of group eligibility
   a. Upon severance of an employer/employee relationship, a person is entitled to purchase an individual life insurance policy, without proof of insurability, within 31 days of separation
   b. Premium for the individual policy will be based on the applicant's attained age on the effective date of the individual policy

2. Death pending conversion **[Sec. 637.566 - .568]**
   a. If a person dies during a conversion period, the insurer will pay the contract as if the insured's coverage was in effect

C. Types of groups/eligible groups

1. Employer-Employee group
   a. Full time employees of a single employer
2. Labor Union Group
   a. Members of a particular union
   b. Policy is held by the union
3. Trustee Group
   a. Group of employees (2 or more employers)
   b. Trustee holds the policy for the members
4. Debtor Group
   a. Debtors of a single creditor
   b. The amount of credit insurance issued cannot exceed the indebtedness of the amount owed
5. Association Group
   a. Any association of professionals, who are licensed by the State of Florida, can obtain an association group life insurance contract.
   b. Requirements
      i. Association must have been in existence for at least two years
      ii. Formed for the purpose other than obtaining insurance
      iii. Hold regular meetings at least on an annual basis
      iv. Contributory Plans; must have at least 100 members participate.
      v. Non-Contributory plans; all members must be covered
6. Credit Union Members
   a. Available to credit unions and their members
   b. Provides equal coverage to the amount of share balance held by the member

D. Employee life

1. Eligibility
   a. In order to be eligible for a group insurance policy, there must be an employee/employer (EE/ER) relationship
   b. The EE/ER relationship must not be discriminatory
      i. All employees of the employer
      ii. All employees of a specific class of employees
2. Employee
   a. Must meet the definition of employee
      i. Employees of one or more subsidiary corporations
      ii. Employees, individual proprietors, and partners, if the employer is an individual proprietor or a partnership.
      iii. Directors of a corporation, former employees, or retired employees

E. Assignment of proceeds [Sec. 627.552 - .571]

   a. A person insured under a group life insurance policy is allowed to make an assignment of all or part of their incidents of ownership under that policy

V. Annuities

A. Suitability

1. Purpose **[Sec. 627.4554; FAC Rule 69B-162.001]**
   a. Require insurance companies to establish a standard and procedure for making recommendations to consumers who are interested in transactions involving annuity products.
2. Recommendation
   a. Advice provided by an insurer or its agent to a consumer that may result in the purchase, exchange, or replacement of an annuity contract
3. Replacement
   a.
   b. Means a transaction in which a new policy or contract is to be purchased and an existing policy or contract will be
      i. Lapsed, forfeited, surrender, assigned, terminated
      ii. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value due to the use of non-forfeiture benefits
      iii. Used in a financial purchase
      iv. Amended to effect a reduction in benefits or cash value

B. Suitability information

1. Means information related to the consumer that is reasonably appropriate to determine the suitability of a recommendation made to the consumer; including the following
   a. Intended use of the annuity
   b. Liquidity needs
   c. Liquid net worth
   d. Financial objectives
   e. Risk tolerance
   f. Tax Status
   g. Financial time horizons
   h. Annual income
   i. Financial experiences
   j. Financial situation and needs, including the financial resources used for funding the annuity
   k. Age
   l. Existing assets, including investment and life insurance holdings

2. Duties of insurers and insurance representatives
    a. When recommending the purchase or exchange of an annuity, the agent and insurance company must have reasonable grounds for believing that the recommendation is suitable for the consumer, and that there is a reasonable basis to believe all of the following
        i. The particular annuity as a whole is suitable
        ii. The consumer has been reasonably informed of various features of the annuity; such as
            (1) Potential surrender charge
            (2) Potential tax penalties
            (3) Other fees
        iii. The consumer will benefit from certain features of the annuity; such as
            (1) Tax-deferred growth
            (2) Annuitization
            (3) Death or living benefit
        iv. In case of exchange or replacement of annuity, the exchange or replacement is suitable whether the consumer
            (1) Will incur a surrender charger
            (2) Be subject to the commencement of a new surrender period
            (3) Lose existing benefits
                (a) Death, living, contractual benefits
                (b) Subject to fees
                    (i) Investment advisory
                    (ii) Riders; product enhancements
                    (iii) General increases
            (4) Would benefit from the product enhancement or improvement
            (5) Has had another annuity exchange or replacement (within the past three (3) years).
        v. Before executing a purchase, exchange, or replacement of an annuity (resulting from a recommendation), the insurance carrier and its appointed agent must make reasonable efforts to obtain the consumer's suitability.
3. Recordkeeping
    a. Companies and agents must maintain records containing information collected from the consumer, as well as other information used in making the recommendations for the basis of the transaction, for a period of five (5) years
    b. A company may maintain the documentation in lieu of an agent
4. Prohibited charges
    a. An annuity contract issued to a senior consumer age 65 or older may not contain a surrender or deferred sales charge for a withdrawal of money from an annuity exceeding 10% of the amount withdrawn

QUESTIONS IN TEXT BOOK = 25

UNIT

29

FLORIDA LAWS & RULES: HEALTH INSURANCE

OVERVIEW

This unit outlines only those marketing practices, policies, and provisions of health insurance that are regulated by the state of Florida. Candidates for the Health Insurance Examination will be tested on the various required laws and rules covered in this unit.

OBJECTIVES

After completing this chapter, you should be able to understand:

- Standard Policy Provisions and Clauses
- Group Health
- Disclosure
- Medicare Supplements
- Long-Term Care Policies
- Requirements for Small Employers
- Florida Health Kids Corporation
- Requirements relating to HIV/AIDs
- Plan Types
- Dread Disease Policy

KEY TERMS

Community Health Purchasing
EPOs (Exclusive Provider Organizations)
Florida Employer Health Care Access Act
Florida Health Insurance Coverage Continuation Act
Free-Look Privilege
Grandfathered Plans
Group Health Insurance
Guarantee-Issue Basis
HMOs
Long-Term Care
Medicare Supplements
PLHSOs
Portability
Preexisting Coverages
Required Contract Provisions
Required Coverages
Small Employer

QUESTIONS IN STATE STUDY MANUAL

25 (Twenty Five)

I. Standard Policy Provisions and Clauses (Individual & Group)

A. Minimum benefit standards

1. Free-look
   a. Health insurance policy may be returned within 10 days of delivery and have a full refund of the premium paid if the purchaser is not satisfied with the policy for any reason
2. Nongrandfathered health plan
   a. Coverage provided by a group health plan in which an individual was enrolled on March 23, 2010, and has continuously covered someone since March 23, 2010
   b. Plans may not have to meet all the requirements contained in PPACA
   c. The following situations could cause a plan to lose grandfathered status **[Sec. 627.402]**
      i. Elimination of benefits
         (1) Elimination of all or substantially all benefits to diagnose or treat a particular condition
         (2) Increase in percentage cost-sharing requirements
            (a) Any increasing percentage cost-sharing requirement
         (3) Increase in a fixed-amount cost-sharing requirement other than a copayment
            (a) If the total percentage increase in the cost-sharing requirement exceeds the maximum percentage increase allowed by federal regulation
         (4) Increase in a fixed-amount copayment
            (a) If the total increase in the copayment exceeds amounts permitted by federal regulation
         (5) Decrease in contribution rate by employers and employee organizations
            (a) Contribution rate based on cost of coverage
            (b) Contribution rate based on a formula
         (6) Changes in annual limits
            (a) Addition of an annual limit
            (b) Decrease in limit for a plan or coverage with only a lifetime limit
            (c) Decrease in limit for a plan or coverage with an annual limit
   d. A group health plan that provided coverage on March 23, 2010, and has retained its status as a grandfathered heal plan is a grandfathered health plan for new employees (whether hired or newly enrolled) and their families enrolling in the plan after March 23, 2010
3. Patient Protection and Affordable Care Act (PPACA) provisions applicable to grandfathered health plans
   a. Group health plans and group and individual health insurance coverage:
      i. May not establish lifetime limits for essential benefits (annual limits may apply)
      ii. May not establish annual limits for essential benefits (annual limits may apply)
      iii. Dependent coverage for adult children
         (1) Must be continued until child turns age 26
      iv. Waiting periods (elimination period)
         (1) Definition
            (a) Delay before benefits are paid
            (b) The insured self-insurers for this period
            (c) Purpose of the waiting period is to control over utilization of the policy
         (2) Provision
            (a) May not establish waiting periods greater than 90 days
      v. May not contain any pre-existing conditions exclusions
4. PPACA provisions NOT applicable to grandfathered health plans
   a. Do not provide free preventative care
   b. Do not have to provide “essential health benefits”

i. Minimum set of benefits that must be covered by a health plan in order to be considered "real" health insurance coverage.

B. Required and optional coverages

1. Medical Provider (physicians and medical doctor) **[Sec. 627.419]**
   a. Also includes
      i. Dentist; when policy covers surgical procedures performed in an accredited hospital with a licensed physician and within the scope of a dentist's professional license
      ii. Medical expense policies must also provide for payment for
         (1) Optometrist
         (2) Chiropractor
         (3) Podiatrist
2. Diabetes coverage: equipment, supplies, and outpatient self-management training **[Sec. 627.6408]**
   a. Florida law requires Health Maintenance Organizations (HMOs) and health insurance contracts to provide coverage for all medically necessary equipment, supplies, and services used to treat diabetes. Certification from a licensed physician is required for proof of condition. This law also includes coverage for outpatient self-management training and education services, if medically necessary
3. Osteoporosis coverage
   a. Bone-thinning disease that increase the risk of bone fractures
   b. Florida health plans and HMOs are required to provide coverage and treatment for high-risk individuals
   c. Excluded
      i. "Specified accident, specified disease, hospital indemnity, Medicare supplement, long-term care health insurance, and Florida state employee health program"
4. Coverage for newborn children
   a. Florida law requires coverage for newborn child(ren) of a covered family for a period of eighteen (18) months
   b. Coverage will consist of
      i. Injury
      ii. Sickness (including)
         (1) Diagnosed congenital defects
         (2) Birth abnormalities
         (3) Prematurity
         (4) Transportation costs (nearest hospital equipped to handle the newborn's condition)
   c. Insured may be required to notify the carrier upon birth of a child. Failure to notify the carrier within 30 days, after the birth, may result in denial of coverage for the newborn
   d. This section does not apply to disability income, hospital indemnity policies or to normal maternity policy provisions applicable to the birthing mother **[Sec. 627.641]**
5. Coverage for adopted, foster, custodial care, and natural-born children
      i. Provides coverage for children of the insured who are
         (1) Natural-born
         (2) Adopted
         (3) Placed by foster care
      ii. Coverage applies from moment of placement to child's 18th birthday
      iii. Exception
         (1) In case of a foster child, the policy may not exclude coverage for any preexisting condition of the child **[Sec. 627-6415]**

b. Children's health Supervision Services
    i. All expense-incurred basis health policies that provide coverage for a family member of the insured must provide benefits applicable for children from the moment of birth to age sixteen (16) for the following
        (1) Medical history
        (2) Physical examination
        (3) Developmental assessment and anticipatory guidance
        (4) Appropriate immunizations and laboratory tests
c. Children with disabilities **[Sec. 627.6615, .0641]**
    i. Individual and group health insurance policies must continue to provide coverage for a child while the child continues to
        (1) Be incapable of self-sustaining employment by reason of intellectual or physical disability
        (2) Be chiefly dependent upon the employee (member, subscriber) for support and maintenance

6. Coverage for mastectomies
    a. Coverage for prosthetic devices and reconstructive surgery for a mastectomy is required by Florida law
    b. Florida law also
        i. Mandates coverage for all surgeries necessary to reestablish symmetry between breasts
        ii. Prohibits inpatient hospital coverage for mastectomies from being limited
        iii. Prohibits a person from being denied or excluded from coverage for breast cancer
            (1) If the person remains cancer-free for two (2) years
        iv. Requires that both outpatient and inpatient postsurgical care coverage for mastectomies be comparable to each other
        v. Prohibits breast cancer follow-up care from being considered an evaluation for a preexisting condition; unless breast cancer is found **[Sec. 627.6417, .64171, .64172]**
7. Coverage for mammograms
    a. Policies delivered in Florida must include coverage for at least the following
        i. Baseline mammogram for any woman age 35 to 39
        ii. Mammogram every two (2) years for any woman age 40 to 49
            (1) More frequently if based on the patient's physician recommendation
        iii. Mammogram every year for any woman age 50 or older
        iv. One or more mammograms a year for any woman who is at risk for breast cancer because of a personal or family history or breast cancer **[Sec. 627.6418]**
8. Exclusions for fibrocystic condition prohibited
    a. Unless the condition is diagnosed through a breast biopsy that demonstrates an increased disposition to developing breast cancer, an insurance carrier may not deny the issuance or renewal of a policy of health insurance because the insured has been diagnosed as having a fibrocystic condition, a nonmalignant lesion, family history related to breast cancer, or any combination of these factors **[Sec. 627.6419]**
9. Coverage for cleft lip and cleft palate of children **[Sec. 627.64193]**
    a. Health insurance policy that covers a child under the age of eighteen (18) years of age must provide coverage for treatment of a cleft lip or palate.
    b. Coverage must also include
        i. Medical
        ii. Dental
        iii. Speech therapy
        iv. Audiology

v. Nutrition service
c. Coverage does not apply to
i. Specified-accident
ii. Specified-disease
iii. Hospital indemnity
iv. Limited benefit disability income
v. Long Term Care insurance (LTCi)

10. Rebates for participation in wellness program **[Sec. 627.6402]**
a. Rebate may be based on premiums paid in the last calendar year or the last policy year.
b. Individual must provide evidence of maintenance or improvement of the individual's health status
c. Rebate not to exceed ten percent (10%) of paid premiums
11. Experimental Treatment for Terminal Conditions
a. Coverage for the cost of, or the cost of services related to the use of, an investigational drug, biological product or device.
b. An insurance company is **not** required, under Florida Insurance Code, to provide this coverage. [Sec. 627.605-.617]
12. Emergency Services
a. Coverage must be provided without prior authorization regardless whether services is provided by participating or non-participating provider.
b. Insurer may only impose a coinsurance, copayment, or limitation of benefits requirement to a non-participating provider if the same applies to a participating provider.
13. Autism Spectrum Disorder and Down Syndrome
a. Health insurance plan or health maintenance contract shall provide coverage for treatment of autism spectrum disorder and down syndrome
b. Treatment shall include:
i. Speech therapy
ii. Occupational therapy
iii. Physical therapy
iv. Applied behavior analysis
14. Opioids
a. Prior authorization requirement may be imposed as long as the policy imposes the same requirement for each occurrence without labeling the claim as an abuse – deterrence. [Sec. 627.64194]

C. Required health insurance policy provisions [Sec. 627.605 - .617]

Policies issued for delivery in Florida must contain the following provision

"An insurer may substitute one or more corresponding provisions of different wording if approved by the Commissioner, and they are not less favorable in any respect to the insured or the beneficiary."

1. Entire contract clause
a. The policy, its endorsements and attached materials, including the application constitute the entire contract
b. No change in the policy will be effective until approved by an officer of the insurance company and attached to the policy
c. No agent may change the policy or waive any of its provisions
2. Time limit on defenses (Time limit on certain defenses)
a. This provision states (generally speaking) that after two (2) years, no misstatements, excepts fraudulent ones, made by the application on the application, shall be used to

void the policy or to deny a claim for a loss incurred commencing after the end of such two-year period.
b. Cannot deny a claim not specifically excluded by name that had existed prior to the policy inception date (preexisting)

3. Grace Period
   a. Period of time after the premiums due during which the policy remains in effect.
      i. 7 days; weekly premium
      ii. 10 days; monthly premium
      iii. 31 days; all other modes
   b. Protects the insured from an unintentional lapse in the policy
4. Reinstatement
   a. A provision which allows the insure to reinstate a lapse policy by paying 60 days back premium due plus interest and providing insurability.
   b. If no action is taken by the carrier within 45 days following a conditional receipt, the policy is reinstated.
   c. Coverage for accidents become effective immediately upon reinstatement
   d. Coverage for sickness does not become effective until the conclusion of a 10 day probationary/incubation period
5. Claim Provisions
   a. Notice of claim (20 days)
   b. Claim forms (15 days)
   c. Proof of loss/Completed claim forms (90 days)
   d. Time of payment of claims (00/30 – immediate/monthly)
   e. Payment of claims
   f. Physical Examination and Autopsy
   g. Legal Action (60 x 5) 5 year Statute of Limitations
6. Study Aid for Claim Provisions
   a. Telephone #: **[(201) 590-0060 x 5]**
      i. 20, 15, 90, 00, 60 x 5
         (1) **20 days**; Notice of Claim
            (a) Tell the insurer within 20 days after the occurrence
         (2) **15 days**; Claim Forms
            (a) Insurer will furnish claim form within 15 days
            (b) If the insured does not receive the claim form within 15 days, the insured may send the company a written statement giving details of the claim, and the company must accept it
         (3) **90 days**; Proof of Loss/Completed claim forms
            (a) Written proof of loss must be furnished to the insurer within 90 days after the loss
            (b) The insured has 90 days to complete the claim forms
         (4) **00 days;** Time payment of claims
            (a) Indemnities payable under medical policies for any loss will be paid immediately (00) upon receipt of due written proof of loss
            (b) Disability income payments are usually made on a monthly basis (30 day interval or periodic period)
         (5) **60 x 5;** Legal Action
            (a) No action at law or in equity shall be brought to recover on this policy
               (i) Prior to the expiration of 60 days after written proof of loss has been furnished
               (ii) After the expiration of five (5) years after the time written proof of loss is required to be furnished
         (6) Payment of claims

(a) Indemnities (benefits) for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment
(b) If no designation is provided, it will be payable to the insured's estate

(7) Physical examination and autopsy
(a) The company, at its own expense shall have the right and opportunity to examine the insured as often as reasonably necessary while a claim is pending
(b) Unless prohibited, by law (not custom or religion), in case of death, may make an autopsy

(8) Change of beneficiary
(a) Unless the beneficiary is designated as irrevocable, the policy owner may make changes to the beneficiary, surrender or assign the policy without the consent of any beneficiary

D. Optional health insurance provisions [Sec. 627.619 - .629]

1. Change of occupation
   a. If an insured changes their occupation to a more hazardous occupation then what is stated in the policy, the insurer will pay only such portion of the benefits provided in the policy as the premium paid would have purchased; at the rates and within the limits fixed by the carrier for such more hazardous occupation
   b. If an insured changes their occupation to a less hazardous occupation then what is stated in the policy, the insurer, upon proof of change of occupation, will reduce the premium rate accordingly and will return the excess pro-rata unearned premium from the date of change of occupation
2. Misstatement of age or sex
   a. If age or sex is misstated, all amounts payable under the policy will be adjusted according to the correct age or sex
   b. Misstatement of age or sex are not subject to the incontestability clause
3. Other insurance with insurer
4. Insurance with other insurers; expense-incurred basis
5. Insurance with other insurers; other than expense incurred basis
6. Unpaid premium
   a. Upon payment of a claim, any premium then due may be deducted from the claim payment
7. Prohibited cancellation for HIV or AIDS
   a. No insurer shall cancel or non-renew the health insurance policy of an insured because of a diagnosis or treatment for the Human Immunodeficiency Virus (HIV) infection or Acquired Immune Deficiency Syndrome (AIDS)
8. Conformity with state statues
   a. If a provision on the policy is in conflict with the state of the state in which the insured resides, the policy will amend itself to conform to the minimum requirements of such statute
9. Illegal occupations
   a. The insurance company shall not be liable for any loss to which a contributing cause was the insured's attempt to commit a felony or to which a contributing cause was the insured's being engage in an illegal occupation
10. Intoxicants and narcotics
    a. The insurance company shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated, or under the influence of, any narcotic unless prescribed by a physician.

II. Group Health Insurance

Group health insurance may be issued to eligible groups in Florida insurance more than one individual **[Sec. 627.651 -.6699]**

A. Eligible groups (employer based, fraternal, association, blanket) [Sec. 627.6516-.656]

1. Trustee group policy
    a. Issued to the trustees of a fund
    b. Consists of:
        i. Groups of employees of employers or members of labor unions
        ii. Insured for the benefit of persons other than the employers or unions
    c. The trustees are the policyholders
    d. Premiums may be paid by
        i. Policyholder
        ii. Employer(s)
        iii. Union(s)
        iv. Insured person
    e. Policy must cover at least five persons.
    f. Amount of insurance under the policy must be based upon some plan precluding individual selection
2. Employee group policy
    a. The employer is the policyholder
    b. Master policy is issued to the employer
    c. Insured for the benefit of persons other than the employer, under a master policy, issued to the employer
    d. Employees can consists of any of the following
        i. Directors of a corporate employer, former and retired employees
        ii. Individual proprietor or partners (sole proprietor / partnership)
        iii. Elected or appointed officials if the policy is issued to insure employees of a public body
        iv. Employees of one or more entities under common control
    e. All persons within the classification specified in the policy are eligible.
        i. Classifications must not be determined so as to exclude those in a more hazardous employment
            a. "Full-Time Employee"
                i. Defined as an employee who has a normal workweek of twenty-five (25) or more hours
3. Associations, labor unions, and small employer health alliances
    a. Made up of groups of individuals insured under a policy issued to an association, including labor unions, as long as
        i. The association has a constitution and bylaws
        ii. The association has at least twenty-five (25) members
        iii. The association has been organized and has been maintained in good faith for a period of at least twelve (12) months for other than the purpose of obtaining insurance
        iv. The association is the policyholder
        v. The association has at a minimum 15 members enroll in the plan
    b. A single master policy is issued to the association
    c. Enrollment in the plan cannot be subject to discrimination
4. Debtor group policy
    a. The creditor is the policyholder
    b. The debtors are indemnified in connection with a specific loan or credit transition
    c. Two types
        i. Credit Disability

(1) May only be issued if the group is to receive entrants at the rate of at least 100 persons annually, or
(2) may reasonably be expected to receive at least 100 new entrants during the first policy year
(3) Company has a right to require evidence of insurability if less than 75% of the new entrants enroll

ii. Mortgage Insurance
(1) Used for all the debtors of the creditor, or all of any class or classes of debtors of the creditor
(2) Debtor includes the following terms
(a) Borrowers of money in connection with an indebtedness of more than 10 years' duration, and is secured by a first real estate mortgage

5. Blanket health insurance
a. A form of health insurance that covers special groups of individuals, including policies owned by and issued to the following:
i. Any common carrier, operator owner, or lessee of a means of transportation covering passengers on that common carrier
ii. Employer, covering any group of employees or the employee's or the employer's dependents or guests defined by reference to activities or operations of the policyholder.
iii. A school, district school system, college, university, or other institution of learning insuring all or any of its students, teachers, and employees.
iv. Any volunteer fire department, emergency services, first aid group, local emergency management agency, or other first responder groups covering members or employees of the policyholder, or covering participants in an activity or operation of the policyholder.
v. An organization, or branch thereof, such as the Boy Scouts of America, the Future Farmers of America, religious, or education bodies.
vi. A Newspaper covering independent contractor newspaper delivery persons.
vii. A health care provider covering patients, donors, recipients, or surrogates.
(1) Plan may not be made a condition of receiving care
(2) Benefits provided must not be assignable to any health care provider.
viii. A sports team, camp, or sponsor thereof covering members, campers, participants, employees, etc.
ix. Travel agent that provides travel-related services to cover any or all persons for whom travel and travel-related services are provided.
x. An association (25 individual members or more) and has been organized and maintained in good faith for at least 1 year for the purposes other than obtaining insurance.

B. Continuation (Mini-COBRA)

1. Purpose and intent **[Sec. 627.6692]**
a. to ensure continued access to affordable health insurance coverage for employees of small employers and their dependents and other qualified beneficiaries not currently protected by the Consolidated Omnibus Budget Reconciliation Act (COBRA), Title X of 1985
b. This section does not apply if continuation of coverage is available to covered employees or other qualified beneficiaries of COBRA
2. Definitions
a. Small employer
i. An business who employs less than 20 employees
b. Group health plan

i. Small employer health benefit plan, which provides health care benefits to the employer's employees, former employees, or the dependents of such employees or former employees

c. Qualified beneficiary
   i. Any individual who is a beneficiary under the group health plan by virtue of the individual being
      (1) Spouse of the covered employee
      (2) Dependent child of the covered employee
      (3) The covered employee
         (a) Except, when the employee is terminated for gross misconduct
   ii. Qualifying event for continuation (Triggers)
      (1) Death of a covered employee
      (2) Divorce or legal separation of the covered employee from the covered employee's spouse
      (3) Termination or reduction of hours of the covered employee's employment
      (4) Dependent child ceasing to be a dependent child under the generally acceptable requirements of the group health plan

3. Continuation of coverage under group health plans
   a. A health plan issued to a small employer must have a provision that provides an offering of coverage to an affected insured, because of a qualifying event or trigger, within the election period, to continue coverage under the employer's group plan
      i. Qualifying beneficiary must give written notice to the insurer within sixty-three (63) days after the occurrence of a qualifying event.
      ii. Within fourteen (14) days after the receipt of the qualified beneficiary's written note, the carrier shall send each qualified beneficiary, by an approved method (certified mail) and election and premium notice form
      iii. A covered employee must pay the initial premium and elect such continuation within 30 days after receiving notice from the insurance company.
      iv. The insurer will process all selections promptly
      v. Coverage and premium due will be retroactively to the date coverage would otherwise have terminated
      vi. Carrier must bill the qualified beneficiary monthly, with a due date on the first of the month and allowing a thirty (30) day grace period
      vii. Premium paid for continuation of coverage may not exceed 115% of the applicable group premium
      viii. Ending date for continuation of coverage is not earlier than the earliest of the following
         (1) 18 months after the qualifying event/trigger
         (2) Qualified beneficiary who is determine to have been disabled at the time of a qualifying event (11 month extension)
         (3) Date on which coverage ceases due to non-payment of a premium
         (4) The data a qualified beneficiary is entitled to benefits under Medicare Part A or Part B
         (5) The date on which the employer terminates coverage under the group health plan for all employees

C. Conversions / "Converted Policy"

1. An insured who has continuously been insured under a group policy at a minimum of three (3) months, immediate prior to termination, is entitled to have issued to them, by the insurance company, a policy or certificate of health insurance; referred to as a "converted policy"
2. The employee or member will not be issued a "converted policy" if

a. Termination of the group insurance occurred because of a failure to make a premium payment
b. Because the discontinued group coverage was replaced by similar group coverage within thirty-one (31) days after discontinuance

3. A written application for a "Converted policy" must be submitted, with the initial premium paid to the insurer, no later than 64 days after termination of the group policy
4. Proof of insurability is not required for issuance of a "converted policy"
5. The premium for a "converted policy" may not exceed 200% of the standard risk rate (established by the Florida OIR)
6. Effective date of the "converted policy" will be the day following the termination of the insurance under the group policy

D. Coordination of Benefits (COB)

1. Policy must contain a provision for coordination it benefits
2. If a claim is submitted and the policy includes a COB provision and the claim involves another insurance policy or plan that also has a COB provision, the following rules apply in order to determine the settlement of the claim
   a. The benefits of a policy or plan that covers the person as an employee, member, or subscriber, other than as a dependent, are determined before those of the policy or plan that covers the persona as a dependent
   b. If the person is also a Medicare beneficiary, and based on the Medicare Secondary Rule, Medicare benefits are secondary, then the person as a dependent of an active employee, the order of benefits is determined as such
      i. 1st; benefits of a plan covering a person as an employee, member, or subscriber
      ii. 2nd; benefits of a plan of an active worker covering a person as a dependent
      iii. 3rd; Medicare benefits
      iv. The rule for the order of benefits for a dependent child when the parents are not separated or divorced are as follows
         (1) The benefits of the plan of the parent whose birthday falls earlier in a year shall be determined before those of the plan of the parent whose birthday falls later in that year
         (2) If both parents have the same birthday, the benefits of the plan which covered the parent longer shall be determined before those of the plan which covered the other parent for a shorter period
         (3) The word "birthday" refers only to month and day in a calendar year and not the year in which the person was born
      v. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child shall be determined as follows
         (1) The plan of the parent with custody of the child shall have its benefits determined first
         (2) The plan of the spouse of the parent with the custody of the child shall have its benefits determined next
         (3) The plan of the parent not having custody of the child shall have its benefits determined last
   c. Coordination of benefits (COB) is not permitted against an indemnity-type policy, an excess insurance policy, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy **[Sec. 627.4235]**

E. ERISA preemption and state insurance regulation

1. Employee Retirement Income Security Act of 1074 (ERISA)

Students should review the State Study Manual for more details.

III. Disclosure

A. Outline of coverage

1. Rule
   a. No policy may be delivered or issued for delivery in Florida, unless it is accompanied by an appropriate "outline of coverage"
   b. "Outline of coverage" must be completed and delivered to the applicant at the time of application and is receipt or certificate of delivery of such outline must be prepared and signed.
   c. The "outline of coverage" must include the following information
      i. Statement identifying the applicable category of coverage provided in the policy
      ii. Brief description of the principle benefits and coverage provided by the policy
      iii. When home health care coverage is provided, a statement that such benefits are provided in the policy **[Sec. 627.642]**
      iv. A summary statement
         (1) of the principal exclusions, limitations, or reductions confined in the policy, pertaining to but not limited to
            (a) Preexisting conditions
            (b) Probationary periods
            (c) Elimination periods
            (d) Deductibles
            (e) Coinsurance
            (f) Age limitations and reductions
         (2) of the renewal and cancellation provisions
            (a) including any reservations of the insurance company of a right to change premiums
         (3) that the outline contains a summary only and that the issued policy should be referred to for the actual provisions

B. Renewal Agreements / Nonrenewal and Cancellation

"Except as provided in this section, an insurer that provides individual or group health insurance coverage must renew the coverage at the option of the individual, or group policyholder" **[627.6425, .6571, .636.028, 641.31074]**

1. Individual health insurance
   a. A company may non-renew or discontinue an individual health insurance policy for one or more of the following reasons
      i. Nonpayment of premium
      ii. An act or practice that constitutes fraud or made an intentional misrepresentation of material facts under the terms of the policy
      iii. Company ceases to offer coverage in the individual market
      iv. Individual no longer resides, lives, or works in the service area
      v. Individual no longer resides, lives, or works in an area where the insurance company is authorized to do business
      vi. Individual ceases to be a member of a bona fide association
   b. If the insurance company decides to discontinue offering a particular health insurance policy form, the insurer must provide notice to each covered individuals at least ninety (90) days before the date of non-renewal
   c. Company must offer each discontinued individual an option to purchase another individual health insurance coverage currently being offered by the company
   d. If the insurer elects to discontinue offering all health insurance coverage in the individual market in the State of Florida, they must provide notice to the Office and to each individual at least 180 days prior to the date of non-renewal

e. When the insurer discontinues all individual health insurance policies in the state, the company may not write individual health insurance coverage in the State of Florida during the next five (5) year period beginning on the date the last health insurance coverage did not renew

2. Group health insurance
   a. An insurance company may non-renew a group health insurance policy for one or more of the following reasons
      i. Nonpayment of a premium
      ii. An act or practice that constitutes fraud or made an intentional misrepresentation of material facts under the terms of the policy
      iii. Company ceases to offer a particular type of coverage in group market
      iv. Policyholder has failed to comply with a material provision of the plan that relates to rules for employer contributions or group participation
      v. There is no longer any enrollee in connection with the plan who lives, resides, or works in the service areas of the insurer
      vi. Employer ceases to be a member of a bona fide association
   b. If the insurance company decides to discontinue offering a particular health insurance policy form, the insurer must provide notice to each covered individuals at least ninety (90) days before the date of non-renewal
   c. Company must offer each discontinued individual an option to purchase another individual health insurance coverage currently being offered by the company
   d. If the insurer elects to discontinue offering all health insurance coverage in the individual market in the State of Florida, the must provide notice to the Office and to each individual at least 180 days prior to the date of non-renewal
   e. When the insurer discontinues all individual health insurance policies in the state, the company may not write individual health insurance coverage in the State of Florida during the next five (5) year period beginning on the date the last health insurance coverage did not renew

C. Advertising

1. All advertisements and communications developed by the insurers regarding insurance products must clearly state that their communications relate to insurance products
2. When selling or soliciting insurance products, agents must clearly indicate to the prospective insured that they are acting as insurance agents with regard to insurance products and identified insurers **[Sec. 626.9531; Rule 69O-150.001-.021]**
3. Advertisements of benefits payable, losses covered, or premiums payable
   a. No advertisement may use words or phrases such as “all”, “full”, “complete”, “comprehensive”, “unlimited”, “up to”, or similar words and phrases in a manner that exaggerates any benefits beyond the terms of the policy
   b. An advertisement, that acts as an invitation to join an association, must distinctly solicit insurance coverage on a separate application
      i. Application and invitation must have separate signature sections as to appear they are not part of the same document
   c. Membership fees must be disclosed on each application and must appear separately so as not to construe that they are part of the premium of the insurance coverage. No advertisement of benefits for which a payment is conditional upon conferment in a hospital or similar setting may use words or phrases such as, “tax free”, “extra cash”, “extra income”, “extra pay” in a manner, that would have the capacity or tendency to mislead or deceive the public in anyway, so that it would enable them to profit from being hospitalized or disabled

d. An advertisement for a policy providing benefits for specialized illness (such as cancer and specified accident, nursing home coverage only) must clearly state in a language identical to, or substantially similar to the following:
   i. "THIS IS A LIMITED POLICY", "THIS IS A CANCER ONLY POLICY", "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY", THIS IS A NURSING HOME COVERAGE ONLY POLICY".
e. An advertisement must disclose exceptions, reductions and limitations effecting the basic provisions of the policy
f. Advertisements must disclose the existence of waiting/elimination periods or probationary/incubation periods

D. Certificate of Coverage [Sec. 627.657]

a. The insurance company must provide to the policyholder a certificate containing the group number and the essential features of the insurance coverage and to whom the benefits are payable to

E. Group blanket health [Sec. 627.660]

a. Covers a number of individuals who are exposed to the same hazards, such as members of an athletic team, college, school or other institution of learning, passengers in the same plane, volunteer fire departments, etc.
b. No certificates or individual policies are issued
c. An individual application is not required from a person covered under a blanket health insurance policy

IV. Medicare Supplement Insurance

1. "Preexisting condition"
   a. May not limit or preclude liability under a policy for a period greater than six (6) months
   b. A condition in which medical advice was given or treatment was recommended within six (6) months prior to the policy effective date
   c. A Medicare supplement policy may not exclude benefits based on a preexisting condition if the individual has had a continuous period of creditable coverage for at least six (6) months prior to the date of application for coverage
2. "Free look"
   a. Medicare supplement policies and certificates must have a statement on the front page of the policy or certificate stating the applicant has thirty (30) days from the date of delivery to have the premium refunded, if the applicant is not satisfied for any reason.
   b. An insurer may not advertise, solicit, or issue for delivery in Florida a Medicare supplement policy or certificate unless it has been filed-with and approved by the Office.
   c. Policy must be written in simplified language and be easily understood by the purchaser **[Sec. 627.674; 69O-156.003, .014]**

B. Open enrollment periods

1. Age 65 and over
   a. Medicare supplement insurance company may not deny any application for Medicare supplement policy of an applicant if the application is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B

2. Under age 65
    a. Medicare supplement insurance company must offer the opportunity of enrolling a Medicare supplement policy to any Florida resident who is under age 65 and is eligible for Medicare by reason of disability or end-stage renal disease
    b. High-pressure tactics & Cold lead advertising is prohibited **[Sec. 627.6743; FAC Rule 69O-156.017]**
3. Permitted compensation arrangements **[Sec. 627.6742; FAC Rule 69O-156.013]**
    a. An agent may receive compensation for the sale of a Medicare supplement policy or certificate only if the first year compensation does not exceed 200% of the compensation paid for selling or servicing the policy in the second year or period
    b. If a company elects to restrict first agent commission or compensation to 15% or less of the policy premium, the company may elect not to pay any commission or other compensation to an agent or other representative for the renewal or replacement of such policy
4. Multiple policies
    a. Medicare supplement insurance may not be issued or sold to an individual if such individual already has enforce a Medicare supplement policy
    b. Exception to rule
        i. If the applicant indicates, in writing, that the intent of the new policy is to replace their current policy
        ii. the insurance company providing the replacement policy forwards the statement to the insurer whose policy is being replaced **[Sec. 627.6744]**

C. Disclosure

1. Buyer's Guide
    a. Must be delivered at the time of application and acknowledged by a receipt
    b. Medicare Supplement Buyer's Guide is developed by the NAIC and Health Care Financing Administration of the US Department of Health and Human Services **[Sec. 627.674]**
2. Outline of coverage
    a. Medicare supplement outline of coverage must be delivered to the applicant at the time the application is made.
    b. The following language must be printed on or attached to the first page of the outline of coverage **[Sec. 627.764]**
        i. **"***This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."*

D. Replacement/Replacement Forms

1. Are when any transaction wherein new Medicare supplement insurance is to be purchased and it is known to the producer (agent, broker) or insurer at the time of application
2. Application forms must include statements and questions designed to elicit information as whether the applicant currently is enrolled in a current Medicare supplement, Medicare Advantage, or Medicaid plan.
3. Notice Regarding Replacement of Medicare Supplement Coverage must be completed
    a. Signed copies to be given to
        i. Agent
        ii. Applicant
        iii. Insurer
    b. Within five (5) working days from the receipt of application, the replacing carrier must furnish a copy of such note to the incumbent carrier, whose policy is being replaced

E. Duplication of benefits

1. No Medicare supplement policy or certificate in force in the state of Florida must contain benefits that duplicate benefits provided by Medicare **[FAC Rule 69O-156.005]**

F. Standardized policy benefits (A-N)

1. ***Specific coverage by plan are discussed in Unit 21, Private Insurance Plans for Seniors***

a. Applicable to all 2010 Standardized Medicare Supplement policies or certificates delivered or issued in the State of Florida with an effective date of June 1, 2010 or later
   i. Medicare supplement policies must be guaranteed renewable
   ii. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state unless if complies with the standards of this section
   iii. Must not indemnify losses resulting from sickness on a different basis than losses resulting from an accident
   iv. A Medicare supplement policy with benefits for outpatient prescription drugs may not be issued after December 31, 2005

V. Long Term Care (LTC) Policies

A. Disclosure

1. Outline of coverage
   a. Must be delivered to an applicant for individual LTCi at the time of application
   b. The outline must include
      i. Description of the principal benefits and coverage provided in the policy
      ii. Statement of the principal exclusions, reduction and limitations
      iii. Statement of the renewal provisions, including any reservation in the policy of a right to change premiums
      iv. Statement indicating that the outline of coverage is a summary of the policy and that the policy should be consulted to determine contractual provision
      v. Must show benefit levels for a period of at least twenty (20) years
      vi. Premium increases and additional premiums must be disclosed for applicants at the age of 75 and 85 years of age **[Sec. 627.9407; 69O-157.120]**
2. Buyer's Guide
   a. Must be delivered prior to the presentation of an application or enrollment form
   b. Must be in a format developed by the NAIC (2001)
   c. Life insurance policies or riders containing accelerated LTC benefits are not required to furnish a LTC Buyer's Guide **[69O-157.121]**

B. Advertising and Marketing

1. An insurance company must file with the Office any LTCi advertising material intended for use in Florida for review or approval.
2. Carriers may immediately begin using material upon filing however, must immediately cease if notice of disapproval or a withdrawal of approval is issued by the Office
3. A qualified LTCi policy must include a disclosure statement within the policy and within the outline of coverage that indicates the policy is intended to be qualified as a long-term contract

   "*This long-term care insurance policy is not intended to be a qualified long-term care insurance contract. You need to be aware that benefits received under this policy may create unintended, adverse income tax consequences to you. You may want to consult with a knowledgeable individual about such potential income tax consequences."*
4. Prohibition against post-claims underwriting
   a. The following language, or language substantially similar to the following must be set out conspicuously on the LTCi policy or certificate at the time of delivery

"*Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained] by you when you applied]. If your answers are incorrect or untrue, the company may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! IF, for any reason, any of your answers are incorrect, contract the company at this address: [insert address].*

5. Requirements for replacement
   a. A Notice Regarding Replacement of Accident and Sickness or Long-Term Care Coverage is required
   b. Sign and executed copies of the notice must be given to
      i. Agent
      ii. Insurer
      iii. Applicant
   c. A copy of the notice must be given to the incumbent company within five (5) working days from the date of the application
6. Producer training
   a. Carriers providing LTCi must maintain records that before their appointed producers sell, solicit, negotiate, or effect any LTCi policy, that they receive necessary and sufficient training to understand partnership policies and their relationship to public and private coverage for LTC
7. Suitability
   a. Every company marketing LTCi must develop and maintain suitability standards to determine whether the purchase or replacement of such policy is appropriate for the needs of the prospective applicant
   b. Both the agent and the insurer must make reasonable efforts to obtain suitability information
   c. A completed personal worksheet must be sent to the insurer prior to the insurer's consideration of the application for coverage
   d. The personal worksheet is provided to the applicant.
   e. If the insurer determines that the applicant does not meet it financial suitability standard, the insurer may reject the application **[Sec. 627.9407; FAC Rule 69O-157.109, .110, .115-.116]**

C. Policy standards

1. Free look
   a. Individual LTCi policies provide for a 30 day period, after delivery of the policy, whereas the insured my return the policy and receive a full refund if they are not fully satisfied with the policy
   b. A policy issued to an individual must not contain renewal provisions other than "guaranteed renewable" or "noncancellable".

2. Preexisting conditions
   a. LTCi definition
      i. "a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person"
      ii. The definition does not prohibit an insurance company from using an application form designed to elicit the complete health history of an applicant; in accordance to company underwriting standards

3. Limitations and exclusions
    a. Mental or nervous disorders
        i. This shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or any other organic brain disease such as senile dementia
        ii. Preexisting conditions or disease
        iii. Illness, treatment or medical conditions arising out of
            (1) War, or act of war
            (2) Participation in a felony, riot, or insurrection
            (3) Service in the armed forces or units auxiliary thereto
            (4) Suicide (same or insane), attempted suicide or intentionally self-inflicted injury
            (5) Aviation (this exclusion applies only to non-fare paying passengers)
            (6) Treatment provided in a government facility
            (7) Treatment provided for alcoholism and drug addiction
            (8) Services for which benefits are available under Medicare or other government programs (excluding Medicaid)
            (9) Services provided by a member of the covered person's immediate family
            (10) Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law
            (11) Services for which no charge is normally made in the absence of insurance
    b. LTCi policy may not do the following
        i. Be cancelled, non-renewed, or otherwise terminated on the grounds of
            (1) Age
            (2) Deterioration of the mental or physical health of the insured individual or certificate holder
        ii. Restrict its coverage to care only in a licensed nursing home
        iii. Condition eligibility for benefits on a prior hospitalization requirement
        iv. Contain an elimination period in excess of 180 days
    c. The premium rate schedule must be based on the issue age of the insured
    d. A LTCi policy may not be issued if the premiums are calculated to increase based solely on the age of the insured
4. Home care coverage
    a. A LTCi policy, certificate, or rider that contains a home health care benefit must meet or exceed the minimum standards set forth in **[Sec. 627.94071]**
        i. Home health care cannot be covered unless the insured would, without the home health care, require skilled care in a skilled nursing facility
        ii. The insured first or simultaneously receive nursing or therapeutic services in a home setting or community setting before home health care services are covered
        iii. Exclude coverage for personal care services provided by a home health aide
        iv. The home health care services must be at a level of certification of licensure greater than that required by the eligible services
        v. The insured/claimant have an acute condition before home health services are covered
        vi. Limiting benefits to services provided by Medicare-certified agencies or providers
        vii. Excluding coverage for adult day care services
5. Inflation protection **[Sec. 627.94072]**
    a. The option to purchase a policy that provides that benefit levels increase with benefit maximums or reasonable durations, to account for reasonably anticipated increases in the cost of services covered by the policy
    b. Provisions that increases benefits annually at a rate not less than five percent (5%) compounded annually

6. Non-forfeiture benefits
    a. An insurance company that offers a long-term care insurance policy must offer a non-forfeiture protection provision if all or part of a premium is not paid.
    b. In addition to the standard nonforfeiture options, a protection provision may be offered in the form of a return of premium upon the death of the insured or upon the complete surrender or cancellation of the policy or contract
    c. The standard non-forfeiture credit must be equal to 100% of the sum of all premiums paid.
    d. The minimum non-forfeiture credit must not be less than thirty (30) times the daily nursing home benefit at the time of the lapse
    e. At the time of the lapse, the carrier must disclose to the insured the insured's then-accrued non-forfeiture values
    f. When the policy is issued, the insurance company must provide to the policyholder a schedule demonstrating the values of non-forfeiture benefits, but the schedule must indicated that the values are estimated and are not to be construed as being guaranteed **[Sec. 627.94072]**
7. Contingent benefit on lapse **[FAC Rule 69O-157.118]**
    a. If the offer to purchase non-forfeiture benefits is rejected, for individual and group policies without non-forfeiture benefits the insurer must include in the policy, or as a rider or endorsement to the policy, the contingent benefit upon lapse
8. Grace period and unintentional lapse **[Sec. 627.94073]**
    a. Grace period of not less than 30 days
    b. If the policy becomes a claim during the grace period (before the premium is paid), the amount of such premium may be deducted from the claim
        i. Interest, not to exceed 8% may be imposed
    c. Unintentional lapse
        i. "Secondary Addressee" is defined as an individual, other than the applicant, to whom receives a notice of lapse or termination of the policy for nonpayment of premiums
        ii. If a policy is cancelled for nonpayment of a premium, the policyholder is entitled to have the policy reinstated, within a period of not less than five (5) months after the date of cancellation if the policyholder or any other "secondary addresses" is able to demonstrate that the reason for the failure to pay the premium was unintentional and due to the policyholder's cognitive impairment, loss of functional capacity, or continuous confinement in a hospital, skilled nursing facility or assisted living facility for a period greater than sixty (60) days
        iii. Reinstatement must be subject to payment of overdue premiums
9. Conditions for determination of benefit payments
    a. Failure to be able to perform any three (3) of the six (6) activities of daily living (ADLs) will trigger the benefits of a long-term care policy
        i. Activities of Daily Living (ADLs)
            (1) Bathing
            (2) Continence
            (3) Dressing
            (4) Eating
            (5) Toileting
            (6) Transferring

D. Required provisions (Minimum standards)

1. All LTC policies must provide coverage for at least one type of lower level form of care.
2. A LTC policy must not provide more coverage for care in a nursing home than coverage for a lower level of care
   a. Different forms of "lower level(s) of care" include
   b. Home Health Services
   c. Assisted Living Facility
   d. Nursing Services
   e. Adult Day Care Center
   f. Personal Care and Social Services
   g. Adult Foster home
   h. Community Care for the Elderly

E. Terminology (See pages 527 – 528 for definitions)

1. Long Term Care Insurance Policy
2. Chronically ill
3. Cognitive impairment
4. Qualified long-term care services
5. Adult day care center
6. Assisted living facility
7. Home health services
8. Nursing home facility
9. Personal care
10. Waiting period or probationary period

F. Long-Term Care Partnership (LTCi-P)

1. Florida's LTCi-P program is a partnership program between Medicaid and private LTC insurers.
2. LTCi-P provides dollar-for-dollar asset protection in the event the policyholder needs to apply for LTC Medicaid assistance
3. A policy or certificate marketed as an approved LTC-P program policy must meet the following criteria
   a. Be a qualified long-term care insurance policy
   b. Have a statement of the principal exclusions, reductions, and limitations
   c. BE issued to a Florida resident or another state that has entered into a reciprocal agreement with Florida when coverage first became effective under the policy
   d. Policies or certificates issued to an individual who has attained age 61 but has not attained age 76 must contain annual inflation coverage **[FAC Rule 69O-157.201]**

VI. Requirements for Small Employers

Purpose and intent

A. Florida Employee Health Care Access Act

1. "To promote the availability of health insurance coverage to small employers regardless of their claims experience or their employees' health status, to establish rules regarding renewability of that coverage, to establish limitations on the use of exclusions for preexisting conditions, to provide for the establishment of a reinsurance program for coverage of small employers, and to improve the overall fairness and efficiency of the small-group health insurance market." **[Sec. 627.6699]**

B. Definitions

1. Dependent
   a. The spouse or child of an eligible employee
2. Eligible employee
   a. An employee who works full-time
   b. Normal workweek of 25 or more hours
   c. Has met any applicable waiting period requirement
3. Guaranteed-Issue basis
   a. An insurance policy that must be offered to an employer, employee, or dependent of the employee, regardless of health status, preexisting condition, or claims history
4. Small Employer
   a. An employer that is actively engage in business
   b. Has its principal place of business in Florida
   c. Employed an average of at least one but not more than 50 eligible employees
5. Small Employer carrier
   a. A carrier that offers health benefit plans covering employees of one or more small employees

C. Special Provisions

1. For employers who have fewer than two employees, a late enrollee may be excluded from coverage for no longer than 24 months if he or she was not covered by credible coverage continually to a date not more than 63 days before the effective date of his or her new coverage
2. An initial enrollment period of at least 30 days must be provided.
3. An annual 30 day open enrollment period must be offered to each small employer's eligible employees and their dependents
4. A small employer carrier must provide a special enrollment period if an eligible employee or dependent was previously covered by other health insurance coverage, and the:
   a. Employee's or dependent's COBRA coverage terminated;
   b. Previous coverage was terminated as a result of loss of eligibility due to legal separation, divorce, death, termination of employment, or reduction in hours of employment;
   c. Coverage was terminated as a result of termination of the employer contributions towards such coverage; or
   d. The employee must request such special enrollment not later than 30 days after the coverage termination date.

D. Denial / Termination / Nonrenewal

1. Small employer carriers do not need to offer coverage or accept application to
   a. A small employer not physical located in an established geographic service area
   b. An employee if the employee does not work or reside within an established geographic service area

E. Fair Market Standards

1. Each small employer insurance company shall actively market health benefit plans coverage to eligible small employers in the state.
2. Small employer carriers must offer and issue all plans on a guaranteed-issue basis
3. No small employer carrier shall terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent with the small employer carrier unless the agent consistently engages in unfair marketing practices

F. Benefit Plans Offered

1. A small employer carrier must file with the Office, at a minimum, the following types of plans
    a. Standard health care plan
    b. High deductible plan (that meets Federal guidelines)
    c. Basic health care plan
2. The small carrier may not use any policy until the insurer has filed it with the Office and has subsequently been approved
3. Standard health benefit plan must include coverage for
    a. Inpatient hospitalization
    b. Outpatient services
    c. Newborn children
    d. Child care supervision services
    e. Adopted children upon placement in the residence
    f. Mammograms
    g. Handicapped children
    h. Emergency and urgent care out of the geographic area
    i. Hospice case
        i. When appropriate and the most cost effective method of treatment

G. Small Employer Rating, Renewability, and Portability Act

1. Rating factors related to age, gender, tobacco use, family composition, or geographic location may be developed by each carrier to reflect the carrier's experience
2. The factors used by insurance companies are subject to Office review and approval.

H. Guaranteed Issue

1. Florida law states that every small employer carrier must offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer. That elects to be covered under such plan.
2. Option rider that provides additional, medically underwritten, benefits may be offered for an additional premium.

I. Small Employer Access Program

1. This plan is intended to provide small employers the option and ability to provide health care benefits to their employees through the creation of a purchasing pool
2. Eligibility to this access plan includes employees of
    a. Employers with up to 25 employees
    b. Municipality
    c. County
    d. School district
    e. Hospital employers nursing home employers (regardless of the number of employees)

J. Stop-Loss insurance

1. An insurance policy issued to a small employer that covers the small employer's obligation for the excess cost of medical care on an equivalent basis per employee provided under a self-insurance health benefits plan.
2. A stop-loss insurance policy is considered a health insurance policy if
    a. it has an aggregate attachment point lower than the greater of $2,000 multiplied by the number of employees;
    b. 120% of expected claims; or
    c. $20,000.

3. Once plan reached the aggregate attachment point, the stop-loss policy must cover 100% of all claims that exceed the aggregate attachment point.

VII. Florida Healthy Kids Corporation

A. Florida Health Kids Corporation (1990)

1. Purpose
   a. Participation in the program is on a voluntary basis
   b. Uninsured children can obtain affordable health care coverage
   c. Funds are collected at the local, state, federal and family level
   d. Coverage can insure services ranging from preventative care to major surgery
2. One of several providers of services for children eligible for medical assistance under Title XXI of the Social Security Act
3. Recipients of this service are school-age children with a family income below 200% of the federal poverty level, who do not qualify for Medicaid

VIII. Requirements Related To HIV/AIDS

A. HIV testing; AIDS exclusion clauses

1. Company must disclose its intent to test the person for HIV
2. Must obtain the person's written informed consent to administer the test
3. Informed consent must include
   a. The purpose, potential use, and limitations of the results
4. If applicant is to test 'POSITIVE' for the HIV infection
   a. Results will be transmitted to a physician designated by the applicant or Department of Health
5. If applicant is to test 'NEGATIVE', notification will not be provided
6. Sexual orientation may not be used in the underwriting process
7. The following may not be used to establish an applicant's sexual orientation
   a. Marital status
   b. Living arrangements
   c. Occupation
   d. Gender beneficiary designation
   e. Postal code (zip code)
   f. Other territorial classifications
8. Company must maintain strict confidentiality regarding medical test results with respect to exposure to the HIV infection or a specific sickness or medical condition derived from such exposure **[Sec. 627.429]**

B. Restrictions on Coverage Exclusions and Limitations

1. No health insurance policy may contain exclusions or limitation with respect to coverage for exposure to the HIV infection, except as provided in a preexisting condition clause

C. Prohibited Cancellation for HIV or AIDS [Sec. 627.6265,. 6646]

1. No insurance carrier shall cancel or non-renew the health insurance policy of any insured because of diagnosis or treatment of HIV or AIDS

IX. Plan Types

A. Health Maintenance Organization (HMO)

1. Employer pays a fixed periodic contribution in advance for the services of participating physicians and cooperating hospitals
2. HMO provides direct medical service in return for a periodic premium (capitation payment).
3. Co-Payment is required

4. HMO Characteristics
    a. Must provide certain basic benefits as set by State Statute
    b. Must provide comprehensive care
    c. Cost control through emphasis on
        i. Preventive care
        ii. Outpatient treatment
        iii. Use of salaried doctors
    d. Typically enrolled on a group basis by their employer

B. Preferred Provider Organization (PPO)

1. Network based form of managed care providers
2. Provide medical care services at a reduced rate
3. Allows plan members to seek medical care and treatment both within and outside of the network
4. If a patient uses a provider within the network, the provider will get paid for the services directly from the insurer
5. A PPO provider is prohibited from “balance billing” or charging any additional amount to the patient above what the provider is paid from the carrier
6. If a patient uses an out-of-network provider, the company must also pay the provider directly for the services, however the provider can charge the patient any difference between what is paid by the carrier and the amount the provider charges for services (Balance Billing). **[Sec. 627.6471, F.S]**
7. A policy issued must include the disclosures indicating
    a. Limited benefits will be paid when non-participating providers are used, and
    b. Nonparticipating providers may require you to pay more than the coinsurance or copayment amount

C. Exclusive Provider Organization (EPO)

1. A provider that has entered into a written agreement with a health insurance carrier to provide health care services for certain insured.
2. Services are offered through
    a. Its own facilities of network health care professionals
    b. Contracted other facilities, such as HMO or PPO
3. Agreement provides reasonable access to these services in the service area
4. Strict criteria are established under law
5. EPO agreements must be approved, inspected, and monitored by the Office
6. Not required to be licensed as insurance agents **[Sec. 636.202, .204, . 210]**

X. Dread Disease Policy

A. Limited risk, Critical illness

1. Policies that provide medical expense coverage for specific kinds of illness
2. Policy benefits are typically paid as
    a. Lump sum
    b. Scheduled benefits
        i. Benefits are used to help defray medical costs associated with a specific medical diagnosis
3. The plans are sometimes known as supplemental plans

QUESTIONS IN TEXT BOOK = 25