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

March 7, 2018

MEMBERS
Governor Rick Scott
Attorney General Pam Bondi
Chief Financial Officer Jimmy Patronis
Commissioner Adam Putnam

Contact: **Caitlin Murray**
(850-413-5005)

8:00 A.M.
LL-03, The Capitol
Tallahassee, Florida

ITEM	SUBJECT	RECOMMENDATION

1. Minutes of the Financial Services Commission for December 13, 2017.

   http://www.myflorida.com/myflorida/cabinet/agenda17/1213/transcript.pdf

   (ATTACHMENT 1) **FOR APPROVAL**

2. Request for Approval for Publication of Rules 69O-203.021,.201,.202,.203,.210; Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations

   The rules will be updated to conform to the statutory changes, implemented by Chapter 2017-112, Laws of Florida, renaming “discount medical plan organizations” to “discount plan organizations” and revising conditions for reimbursement, disclosure requirements, reporting requirements, fee requirements, marketing requirements, and the authority for the Financial Services Commission to adopt rules.

   (ATTACHMENT 2) **APPROVAL FOR PUBLICATION**

3. Request for Approval for Publication of Repeal of Rules 69O-203.204,. 205; Filing Approval of DMPO Plans, Rates and Related Forms; Bundled Products

   The rules are being repealed to conform to the statutory changes, implemented by Chapter 2017-112, Laws of Florida. These rules are obsolete.

   (ATTACHMENT 3) **APPROVAL FOR PUBLICATION**

4. Request for Approval for Final Adoption of Rule 69O-191.029; Maintaining Eligibility for Certificate of Authority

   The current rule requires an HMO to be operational within six months of licensure. This creates a conflict with the changes to Section 641.221, Florida Statutes, which allows an HMO limited to Medicare Advantage plans up to 24 months after licensure to become operational. The rule will be updated to conform to the statutory changes.

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

5. Request for Approval for Final Adoption of Rule 69O-150.206; Marketing Communications of Benefits Payable, Losses Covered, and Premiums Payable

   Amends rule to remove marketing requirements due to statutory change that removed requirement for insurers to offer Basic and Standard Health benefit plans.

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

6. Office of Insurance Regulation 2nd Quarter Report FY 2017-18

   (ATTACHMENT 6) **FOR APPROVAL**

1 **OFFICE OF INSURANCE REGULATION**

2

3 GOVERNOR SCOTT: Next I'd like to recognize
4 David Altmaier with the Office of Insurance
5 Regulation.
6 COMMISSIONER ALTMAIER: Good morning, Governor
7 and Cabinet. It's nice to be here.
8 We have five items on our agenda. The first
9 one is the approval of the minutes from the October
10 the 17th, 2017 --
11 GOVERNOR SCOTT: Is there a motion on the
12 item?
13 COMMISSIONER PUTNAM: So moved.
14 GOVERNOR SCOTT: Is there a second?
15 CFO PATRONIS: Second.
16 ATTORNEY GENERAL BONDI: Second.
17 GOVERNOR SCOTT: Comments or objections?
18 (NO RESPONSE).
19 GOVERNOR SCOTT: Hearing none, the motion
20 carries.
21 COMMISSIONER ALTMAIER: Thank you.
22 Item Number 2 is the appointment of a new
23 member to the Florida Workers' Compensation Joint
24 Underwriting Association board; that's the workers'
25 comp JUA.

1 We are recommending Robert Deveer be appointed
2 to this position to represent what we call foreign
3 insurance companies, which are insurance companies
4 that are just simply domiciled in a state outside
5 of Florida. So we respectfully request your
6 approval of that appointment.
7 GOVERNOR SCOTT: Is there a motion on the
8 item?
9 CFO PATRONIS: So moved.
10 GOVERNOR SCOTT: Is there a second?
11 COMMISSIONER PUTNAM: Second.
12 GOVERNOR SCOTT: Comments or objections?
13 (NO RESPONSE).
14 GOVERNOR SCOTT: Hearing none, the motion
15 carries.
16 COMMISSIONER ALTMAIER: Thank you.
17 I believe with your permission we could do
18 Agenda Items 3 and 4 together. Both of these are
19 requesting approval for publication, sets of rules
20 that have -- that require amendments because of
21 statutory changes. So we would request approval to
22 publish those.
23 GOVERNOR SCOTT: Is there a motion?
24 CFO PATRONIS: So move.
25 GOVERNOR SCOTT: Is there a second?

1 COMMISSIONER PUTNAM: Second.
2 CFO PATRONIS: That's 3 and 4?
3 GOVERNOR SCOTT: Yeah.
4 Comments or objections?
5 (NO RESPONSE).
6 GOVERNOR SCOTT: Hearing none, the motion
7 carries.
8 The Commissioner did the second.
9 COMMISSIONER ALTMAIER: And then Agenda Item
10 Number 5 is the submission of our first quarter
11 report for the fiscal year 2017/2018, which I
12 believe are in your materials. We'd be happy to
13 answer any questions that you might have about
14 that; otherwise, we'd respectfully request your
15 approval of that.
16 GOVERNOR SCOTT: Any questions?
17 (NO RESPONSE).
18 GOVERNOR SCOTT: Okay. Is there a motion on
19 the -- a motion to accept the report?
20 ATTORNEY GENERAL BONDI: So move.
21 GOVERNOR SCOTT: Is there a second?
22 CFO PATRONIS: Second.
23 GOVERNOR SCOTT: Comments or objections?
24 (NO RESPONSE).
25 GOVERNOR SCOTT: Hearing none, the motion

1 carries.
2 COMMISSIONER ALTMAIER: Thank you so much.
3 GOVERNOR SCOTT: Thank you, David. Have a
4 good Christmas.
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M E M O R A N D U M

DATE: February 20, 2018

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Sarah Berner, Assistant General Counsel
Alyssa Lathrop, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 7, 2018
Request for Approval to Publish Amendments to
Rules 69O-203.021, .201, .202, .203, .210
Assignment # 216001-17

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before February 28, 2018, and to the Financial Services Commission on March 7, 2018, with a request to approve for publication the proposed rules.

The rules will be updated to conform to the statutory changes, implemented by Chapter 2017-112, Laws of Florida, renaming "discount medical plan organizations" to "discount plan organizations" and revising conditions for reimbursement, disclosure requirements, reporting requirements, fee requirements, marketing requirements, and the authority for the Financial Services Commission to adopt rules.

Sections 624.424; 636.232; 636.202; 636.204; 636.208; 636.216; 636.218; 636.220; 636.226; 636.228; 636.230; 636.234; 636.236; 636.067; 636.007; 636.008, F.S., are the rulemaking authority and laws implemented for these rules.

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

Approved for signature:

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier, Commissioner
Office of Insurance Regulation

PREPAID LIMITED HEALTH SERVICE ORGANIZATIONS AND DISCOUNT ~~MEDICAL~~ PLAN ORGANIZATIONS

69O-203.021 Standards for Fingerprint Cards for New Applicants and Acquisition Applications.

(1) No Change

(2) The Office has adopted Form OIR-C1-938 (rev. 5/13 ~~4/91~~), incorporated by reference in Rule 69O-203.100, F.A.C., which provides instructions on how fingerprint cards are to be completed.

Rulemaking ~~Specific~~ Authority 636.067 FS. Law Implemented 636.007, 636.008 FS. History–New 11-15-94, Formerly 4-203.021, Amended ______________.

69O-203.201 Definitions.

(1) No change.

(2) Contract or Form means the document, by whatever name called; such as agreement, certificate or handbook which describes the benefits under the discount ~~medical~~ Plan.

(3) Discount ~~Medical~~ Plan (Plan) means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive one or more medical services from those providers at a discount.

(4) DPO ~~DMPO~~ is the Discount ~~Medical~~ Plan Organization defined in Section 636.202(2), F.S., that contracts with providers, provider networks, or other D~~M~~POs, to provide discounted medical services to Plan members and determines the charges to the members.

(5) No change.

Rulemaking ~~Specific~~ Authority 636.232 FS. Law Implemented 636.202 FS. History–New 4-7-05, Amended________________.

69O-203.202 Standards for Discount ~~Medical~~ Plans.

(1) No change.

(a) Name and address of the DPO ~~DMPO~~;

(b) –(i) No change.

(j) Provisions for adding new family members; <u>and</u>

(k) ~~All plan contracts and application forms shall have a unique form number in the lower left hand corner; and~~

~~(l)~~ Member complaint procedure.

(2) No change.

~~(3) (a) All charges to members must be filed with the Office, and the Office must approve any periodic charge exceeding $30.00 per month, or $50.00 per month as provided by paragraph 69O-203.204(1)(b), F.A.C., for the contract issued and not per member covered on the contract, before the periodic charges can be used. Periodic charges approved pursuant to this paragraph must remain in compliance with this paragraph. Consequently, subsequent to the initial approval, the periodic charges remain subject to review by the Office to ensure continued compliance.~~

~~(b) In a filing made pursuant to paragraph (a) above, the discount medical plan organization has the burden of proof that the periodic charges bear a reasonable relationship to the benefits received by the member. If the discount medical plan organization uses member savings as the basis of demonstrating the benefits received by the member, the benefits shall be benefits and savings that can be reasonably anticipated by an average Floridian who may purchase such contract.~~

~~(c) A discount medical plan organization may, at its option, make a filing that meets one of the following standards that have been determined to meet the requirement of paragraph (b) above:~~

~~1. The discount medical plan organization provides financial information to demonstrate that at least sixty percent (60%) of the periodic charge is used to pay the costs associated with providing access to discount medical services, excluding any administrative costs, commissions and profits; or~~

~~2. The discount medical plan organization provides financial information to demonstrate that the plan's periodic charge does not exceed sixty percent (60%) of the actual benefit of the discounted services to members, measured as the actual savings realized by members, i.e., provider billed charges without the discount less the discounted provider~~

~~charges paid by the member. These values shall be measured in the aggregate for all members and all actual services utilized over a period of twelve months with experience from at least 2,000 members; or~~

~~3. The discount medical plan organization provides specific financial information to demonstrate that at least seventy-five percent (75%) of the periodic charge is used to pay the costs associated with providing access to discount medical services, member support services and administrative costs excluding commissions and profits.~~

Rulemaking ~~Specific~~ Authority 636.232 FS. Law Implemented 636.216 FS. History–New 4-7-05, Amended 11-1-07, Amended______________.

69O-203.203 Standards for the Form and Content of Advertisements or Marketing Materials.

(1) No change.

(2) (a) – (c) No change.

(d) The term "insurance" may not be used as a descriptive term for DPO ~~DMPO~~ benefits. However, the term "insurance" may be used in a disclaimer of any relationship between DPO ~~DMPO~~ benefits and insurance including the disclosures required in Section 636.212, F.S.

Rulemaking ~~Specific~~ Authority 636.232 FS. Law Implemented 636.228 FS. History–New 4-7-05, Amended______________.

69O-203.210 Forms Incorporated by Reference.

(1) The following forms are incorporated herein by reference to implement the provisions of Chapter 636, Part II, F.S.:

(a) The following forms which are hereby adopted:

	FORM #	TITLE	DATE
1.	OIR-C1-1606	APPLICATION FOR LICENSE DISCOUNT ~~MEDICAL~~ PLAN ORGANIZATION (DPO)	01/18

	FORM #	TITLE	DATE
	http://www.flrules.org/Gateway/reference.asp?No=Ref-08285	(~~DMPO~~)	~~12/05~~
2.	OIR-C1-1423 http://www.flrules.org/Gateway/reference.asp?No=Ref-08283	BIOGRAPHICAL AFFIDAVIT	12/17 ~~08/20/14~~

(b) The following forms as adopted in Chapter 69O-136, F.A.C. and 69O-143:

	FORM #	TITLE	DATE
1.	OIR-C1-144	SERVICE OF PROCESS CONSENT & AGREEMENT	06/04 ~~01/97~~
2.	~~OIR-C1-903~~ ~~http://www.flrules.org/Gateway/reference.asp?No=Ref-08290~~ ~~(12/05)~~	~~INVOICE FOR NON-US CITIZENS WITH NO SOCIAL SECURITY NUMBER REQUEST FOR PAYMENT OF FINGERPRINT CHARGES~~	~~12/05~~
3.	OIR-C1-938 http://www.flrules.org/Gateway/reference.asp?No=Ref-08296	FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE	05/13
4.	OIR-C1-1298 http://www.flrules.org/Gateway/reference.asp?No=Ref-06557	MANAGEMENT INFORMATION FORM COMPLETE LIST OF OFFICERS, DIRECTORS, AND SHAREHOLDERS (10% OR MORE)	03/15 ~~10/05~~

(c) OIR-A1-1671, Annual Report – Discount ~~Medical~~ Plan Organizations (06/08).

(2) All of the above referenced forms are available and may be printed from the Office of Insurance Regulation's website: http://www.floir.com/iportal.

Rulemaking Authority 624.424(1)(c), 636.232 FS. Law Implemented 624.424, 636.204, 636.218, 636.220, 636.226, 636.228, 636.234, 636.236 FS. History–New 5-22-05, Amended 10-29-08, 7-30, Amended__________.

Office of Insurance Regulation
Life & Health Financial Oversight

FLORIDA
COMPANY CODE:
__ __ __ __ __

FEDERAL EMPLOYER
IDENTIFICATION NUMBER
__ __ -- __ __ __ __ __ __ __

ANNUAL REPORT

OF THE

____
NAME OF THE DISCOUNT ~~MEDICAL~~ PLAN ORGANIZATION (DPO) ~~(DMPO)~~

____
(CITY)

____
(STATE)

TO THE

OFFICE OF INSURANCE REGULATION

OF THE

STATE OF FLORIDA

Life & Health Financial Oversight
200 East Gaines Street
Tallahassee, FL 32399 - 0327

FOR THE FISCAL YEAR ENDED

____

DUE ON OR BEFORE

3 MONTHS AFTER THE END OF EACH FISCAL YEAR END

REPORT MUST BE TYPED OR PRINTED

OIR-A1-1671
(XX/XX)
69O-203.210

DRAFT

Name of Discount ~~Medical~~ Plan Organization (DPO) ~~(DMPO)~~:

____

Annual Report of DPO ~~DMPO~~ to the Florida Office of Insurance Regulation
For Fiscal Year Ending ______________________

Federal Employer Identification Number (FEIN)	__ __ -- __ __ __ __ __ __ __
Complete address of DPO's ~~DMPO's~~ principal office	
Full name & title of DPO's ~~DMPO's~~ chief executive officer	
Web Site (s. 636.204 (4))	
Type of entity (check one)	___ Corporation - For profit ___ Corporation - Not-for-profit ___ Partnership ___ Sole proprietorship ___ Limited liability company ___ Other:

This annual report shall be signed below by two corporate officers of the DPO ~~DMPO~~, if the DPO ~~DMPO~~ is a corporation; the DPO's ~~DMPO's~~ partners, if the DPO ~~DMPO~~ is a partnership; the DPO's ~~DMPO's~~ owner , if the DPO ~~DMPO~~ is a sole proprietorship; or the DPO's ~~DMPO's~~ managing or other duly authorized member, if the DPO ~~DMPO~~ is a limited liability company.

Printed name		Printed name	
Title		Title	
Signature		Signature	

Name of Discount ~~Medical~~ Plan Organization <u>(DPO)</u> ~~(DMPO)~~:

____

Annual Report of <u>DPO</u> ~~DMPO~~ to the Florida Office of Insurance Regulation
For Fiscal Year Ending _____________, 20 ___ ___

Instructions

1. Within 3 months after the end of each fiscal year, complete and file this report for the preceding fiscal year with:

    The Office of Insurance Regulation
    Life & Health Financial Oversight
    200 E. Gaines Street
    Tallahassee, Florida 32399-0327

2. Provide all requested information on page 2. Have the report signed on page 2 consistent with the instructions thereon.

3. Answer questions a through r on pages 4 and 5, as they pertain to the fiscal year covered by this report. Attach any additional information and/or documentation required as a result of your responses, clearly identifying each attachment and the question number being answered.

4. Attach a copy of the audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement, and statement of changes in cash flow for the preceding fiscal year.

    An organization that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the organization may petition the office to accept, in lieu of the audited financial statement of the organization, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the organization required by this part will be met by the parent entity. The Office may accept this petition if all of the following are met:

    - The licensee is 100% owned by the parent directly or indirectly
    - The parent receives an unqualified opinion
    - The parent's audited financial statement reflects at least a $5 million net worth on a GAAP basis
    - The parent provides a parental guarantee ~~as described in s.636.216 (2)(a), F.S.~~
    - The licensee provides un-audited financial statement on a GAAP basis attested to which reflects a surplus of $150,000 or more.
    - Licensee requests petition in writing at least 30 days prior to due date of annual report

5. If different from the initial application or the last annual report, complete the schedule on page 7, and include the complete names, address, or Federal taxpayer identifying numbers, titles, and ownership percentages of all officers, directors, managing members, and 10% or greater owners, and for each indicate whether that individual is an officer, director, and/or owner. Please disclose the extent and nature of any contracts or arrangements between such persons and the <u>DPO</u> ~~DMPO~~, including any possible conflicts of interest. Attach additional pages as needed.

6. For each individual who, during the period covered by this report, was a member of the DPO's ~~DMPO's~~ Board of Directors, Board of Trustees, Executive Committee, or other governing board or committee, or who was one of its principal officers or managing members, responsible for the conduct of its affairs, or in a position to exercise control or influence over its affairs, **and for whom the DPO ~~DMPO~~ has not previously done so**, (1) make arrangements to have an investigation report forwarded directly to the Office, and (2) attach to this report: (a) a statement informing the Office of the date that such investigative report was requested, (b) completed NAIC Biographical Statement and Affidavit, and (c) two completed Florida fingerprint cards. Only Florida fingerprint cards will be accepted. Florida fingerprint cards may be obtained by calling the Office of Insurance Regulation, L&H Financial Oversight, at (850) 413-5052.

7. As stated in s.636.204(3), "The office shall issue a license which shall expire 1 year later, and each year on that date thereafter, and which the office shall renew if the licensee pays the annual license fee of $50 and if the office is satisfied that the licensee is in compliance with this part." Attach evidence of your $50 renewal fee being paid to the Department of Financial Services, Revenue Processing Section, P.O. Box 6100, Tallahassee, Florida 32314-6100. Page 8 of this report should be detached and mailed to the address given, along with your check for $50, **prior to the anniversary date of the DPO ~~DMPO~~ obtaining its license.**

8. Answer the questions below as they pertain to the fiscal year covered by this report. Attach any additional information and/or documentation required as a result of your responses.

		Yes	No
a	Have there been any changes to any of the DPO's ~~DMPO's~~ basic organizational documents, such as its bylaws or articles of incorporation? If so, attach an explanation of all such changes, and copies of the amended documents.		
b	Have there been any changes in the DPO's ~~DMPO's~~ ownership? If so, attach a statement containing complete details, and an organizational chart depicting all direct and indirect relationships between the DPO ~~DMPO~~ and all of its affiliates, including the ultimate parent corporation of all such entities.		
c	Was the DPO ~~DMPO~~ a party to any civil or criminal legal action, other than as plaintiff in a civil matter? **If so, attach a statement containing complete details.**		
d	Is the DPO ~~DMPO~~ doing business in any state(s) other than Florida? If so, attach a schedule of all such state(s).		
e	Was the DPO's ~~DMPO's~~ license, registration, or certificate of authority to act as a DPO ~~DMPO~~ suspended or revoked by any governmental agency, or did any governmental agency initiate formal legal proceedings for said purpose? **If so, attach a statement containing complete details.**		

f	Has any governmental entity imposed fines or costs, other than normal filing fees or renewal fees, for activities arising from DPO ~~DMPO~~ operations? **If yes, attach a statement containing complete details.**		
g	Has the DPO ~~DMPO~~ either maintained a surety bond in its own name, or securities eligible for deposit with Collateral Management, in an amount not less that $35,000?		
h	Are all advertisements, marketing materials, brochures, and discount cards used by marketers approved in writing for such use by the DPO ~~DMPO~~?		
i	Does the DPO ~~DMPO~~ have an executed written agreement with each marketer prior to the marketer's marketing, promoting, selling, or distributing the DPO ~~DMPO~~?		
j	Is the DPO ~~DMPO~~ monitoring the content of all its websites for compliance with s.636.210, s.636.212, and s.636.226 Florida Statutes?		
k	Did the DPO ~~DMPO~~ fail to pay any judgment rendered, if any, against it in any state within 60 days after the judgment became final? **If so, attach a statement containing complete details.**		
l	Was the DPO ~~DMPO~~ at any time unable to fully pay when due any debts, or to timely meet any other obligations: **If so, attach a statement containing complete details.**		
m	Was the DPO ~~DMPO~~ or any of its owners, officers, or directors, convicted of, or did it (or that person) enter a plea of guilty or nolo contendere to a felony in any state without regard to whether adjudication was withheld**?** **If so, attach a statement containing complete details.**		
~~n~~	~~Have all forms required by statute being used been filed with and approved by the Office?~~		
~~o~~	~~Have all charges to members been filed with the Office and any charge greater than $30 per month or $360 per year been approved by the Office?~~		

		Florida
n ~~p~~	For the year covered by this report, what was the total amount of revenue collected for Florida DPO ~~DMPO~~ business?	$
o ~~q~~	How many residents of Florida are members of the DPO ~~DMPO~~?	

p ~~r~~	List the internet websites used by the DPO ~~DMPO~~ and its marketers.

Name of Discount ~~Medical~~ Plan Organization (DPO) ~~(DMPO)~~:

____

Annual Report of DPO ~~DMPO~~ to the Florida Office of Insurance Regulation
For Fiscal Year Ending ____________, 20 ___ ___

CHECK LIST

Please indicate by checking the boxes that each action has been taken

[_] This Report has been completed in its entirety with all schedules.

[_] Audited CPA financial statements and Opinion Letter are attached.

[_] Separate responses, cross-referenced to the question, are attached where appropriate.

[_] All financial statements and schedules are mathematically correct.

[_] If required, biographical statements, background investigative reports, and fingerprint cards

[_] Evidence of payment of license renewal fee.

[_] Requests for clarification may be sent electronically to the e-mail address below.

The person to contact regarding any information contained in this report is:

____

(name & position / title)

____

(address)

____

(city, state, zip)

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ EXT: ___ ___ ___ ___ ___
(area code - telephone number - extension)

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
(area code - fax number)

____

(e-mail, if applicable)

Name of Discount ~~Medical~~ Plan Organization (DPO) ~~(DMPO)~~:

____

Annual Report of DPO ~~DMPO~~ to the Florida Office of Insurance Regulation
For Fiscal Year Ending _______________, 20 ___ ___

MANAGEMENT / OWNERS INFORMATION

Provide the requested information for all new Officers, Directors, or Other Individuals Responsible for the Operations of the Licensee; include percentage of ownership in the % column. Also, provide the requested information for all new Owners (Members of the Licensee's Organization) with an interest of 10% or greater. If the new Owner is a company, partnership, or other organization, enter the requested information on the last line.

(See instruction 6 on page 3.)

	Name	Position/Title	Residence Address	FEIN	%

(If additional space is needed attach a separate sheet to this Schedule.)

For each of the individuals listed above, has the information required by item 5 of the instructions been included? _______

For each of the individuals listed above, are the attachments required by item 6 of the instructions been included? _______

Have all new officers, directors, and owners been revealed? _______

The following Officers and Directors are no longer associated with the DPO ~~DMPO~~: _____________________
____

The following, previously reported as having an ownership interest in the DPO ~~DMPO~~, no longer have an ownership interest:

____
____

Office of Insurance Regulation
Life & Health Financial Oversight

REMITTANCE FORM

Detach and separately forward this page prior to the due date of the required license renewal with your payment to the address below.

Name of Discount ~~Medical~~ Plan Organization	
Street address	
City, State, Zip	
Federal Employer Identification Number	__ __ -- __ __ __ __ __ __ __
Florida Company Code	__ __ __ __ __
Renewal Date of License	____________________ **2 0** __ __

ATTACH CHECK FOR $50.00 HERE.

MAKE CHECK PAYABLE TO
DEPARTMENT OF FINANCIAL SERVICES

MAIL PAYMENT & THIS PAGE TO:

DEPARTMENT OF FINANCIAL SERVICES
REVENUE PROCESSING SECTION
P. O. BOX 6100
TALLAHASSEE, FLORIDA 32314-6100

FOR OFFICE OF INSURANCE REGULATION USE ONLY

AMOUNT	TYPE/CLASS	FEE	FUND ACCOUNT
$50.00	1300	L	Renewal License Fee

SERVICE OF PROCESS CONSENT & AGREEMENT

(Please type or print all information clearly)

O Original Designation O Insurer Name Change O Merger/ Acquisition O Update Delivery Information

Insurer or Company Name:______________________________

Previous Name (If applicable):------------------------------
Home Office Address: ______________________________
City, State, Zip ______________________________

______________ FEI# ______________ FL Company Code ______________ Telephone#

Know all men by these present, that the insurer or other entity named above is subject to the statutory agent for service of process provisions of the Florida Insurance Code duly organized and existing under and by virtue of the laws of the state of domicile.

Said entity does hereby agree and consent that actions may be commenced against it in any court having jurisdiction in any county in the State of Florida, in which a cause of action may arise, or in which the plaintiff may reside, by the service of process upon the Chief Financial Officer of the State of Florida. Said entity also hereby stipulates and agrees that any and all process so served shall be taken and held in all Courts to be as valid and binding upon this insurer or other entity as if personal service had been made upon the President or Secretary, or any other duly authorized and accredited officer thereof

The undersigned hereby further agrees and stipulates that this agreement is and shall remain irrevocable, so long as there is liability, under any policy, claim or cause of action within this state, either fixed or contingent. Said insurer or other entity does hereby designate the following as the name and address of the person to whom all process is to be forwarded when process is served upon said Chief Financial Officer of the State of Florida on behalf of the above named insurer or entity, **In the event of a change in the name of the insurer or the designation of the person to whom process is to be forwarded, whether it be name, address, and/or phone or fax numbers, the insurer or company shall immediately file a new agreement form with the** Chief Financial Officer of the State of Florida **at the address shown at the bottom of this page.**

Designated Person to receive process:______________________________

E-Mail Address:______________________________
Phone#:______________ **Fax#**______________

Mailing Address: ______________________________
____
____

Street Address____ ------------------------------
____
____

Signature: ______________________________
I hereby consent and agree to be the person to whom process served upon the Chief Financial Officer of the State of Florida for said entity, may be forwarded.

In Witness Whereof, we, the President or Chief Executive Officer and Secretary of said insurer or other entity, being duly authorized by the Board of Directors or governing body of this entity to execute this document, have hereunto set our hands and affixed the seal of said insurer or other entity on this the___________day of___________, AD.___________.

____
President or CEO's Signature

____
President or CEO's Name(Typed or Printed)

SEAL

____
Secretary's Signature

____
Secretary's Name (Typed or Printed)

Any signatures other than the President, CEO, or Secretary for the Company must be validated by the attachment of a resolution of the Board of Directors or Governing body of said company delegating the authority to sign for the company.

69O-203.100
69O-191.107
OIR-C1-144
Rev 06/2004

Service of Process Section
200 East Gaines Street• PO Box 6200 • Tallahassee, FL 32314-6200 •(850) 413-4200 • Fax (850) 922-2544

Office of Insurance Regulation
Company Admissions

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

LiveScan (available to Florida Residents):

Applicants must pay online for processing of electronic fingerprints and make appointment for electronic fingerprinting. To begin the process, access MorphoTrustUSA

- Select English or Spanish to continue
- Enter First Name and Last Name
- Select "Continue"
- Enter Zip Code to determine closest fingerprint location or Choose "Region" and select "Go"
- Schedule Appointment
- Enter Applicant Information and select "Send Information"
- Verify and Select "Go"
- Select "Method of Payment" and "Send Payment Information"
- Select "Continue to US Bank E-Pay"
- Retain copy of payment confirmation

Paper Card* (available to Florida Residents and Non-Residents):

Applicants must pay online for processing fingerprint cards. To begin the process, access MorphoTrustUSA

- Select English or Spanish to continue
- Enter First Name and Last Name and select "Go"
- Select "Non-Resident Card Submission" (Non-Residents and Florida Residents not utilizing LiveScan)
- Select "No Cards"
- Enter Applicant Information and select "Send Information". If Applicant does not have a Social Security Number, enter "123-12-1234" in the required SSN field
- Verify and Select "Go"
- Select "Method of Payment" and "Send Payment Information"
- Select "Continue to US Bank E-Pay"
- Retain copy of payment confirmation
- Mail completed cards with a cover letter to: Florida Office of Insurance Regulation
Company
Admissions 200 East
Gaines Street
Tallahassee, Florida 32399-0332

Applicants may contact MorphoTrust USA's toll free registration center at 1-800-528-1358 regarding payment and/or appointment issues.

*Applicants must use fingerprint cards provided by the Office. Applicants must provide **two** completed cards per person. Blank fingerprint cards may be requested by emailing appcoord@floir.com or calling 850-413- 2575.

Payment confirmations will be a required component in the electronic application submitted via iApply. Questions may be emailed to appcoord@floir.com.

CONFIDENTIAL

Pursuant to sections 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07, Florida Statutes, and section 24(a), Art. I of the State Constitution. The requirement must be relevant to the purpose for which collected and must be clearly documented. The social security numbers must be segregated on a separate page from the rest of the record.

Applicant's Name: ____

Applicant's Social Security Number: _______________________________________

The requirement for the applicant's social security is mandatory.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to insure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year. In establishing these qualifications and the Office of Insurance Regulation's responsibility to ensure that individuals meet these qualifications, the legislature recognized that owners, officers, and directors of an insurance company are in a position to cause great harm to public should they be untrustworthy or have a criminal background. These individuals control vast amount of funds that belong to policyholders. To meet the legislative intent that these people are qualified to be trusted, having the identifying social security number is essential for the Office of Insurance Regulation to adequately perform the background investigative duty. There are many individuals with the same name, without this identifying number it would be difficult if not impossible to be reasonably sure that the correct individuals are identified and verify they meet the statutorily required conditions.

CONFIDENTIAL

Office of Insurance Regulation
Company Admissions

APPLICATION FOR LICENSE
DISCOUNT ~~MEDICAL~~ PLAN ORGANIZATION (D~~M~~PO)

The Office receives applications electronically. Please submit your application at http://www.floir.com/iportal, using the iApply link to Online Company Admissions.

This package is designed to assist individuals in preparing the application with all the information required by statute and to facilitate expeditious processing of the application by this Office.

PLEASE NOTE: THE COMPLETED CHECK LIST MUST BE SUBMITTED WITH THE APPLICATION PACKAGE.

The completed application package must be submitted to the Office by utilizing the following link:

http://www.floir.com/iportal
and select iApply – Online Company Admissions

If this package requires submission of forms and/or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal http://www.floir.com/iportal and select "Form & Rate Filing Assembly and Submission" to begin the submission of forms and/or rates.

If this package requires original documents, in lieu of providing original paper documents, the Applicant is directed to submit a PDF of the original document(s) unless otherwise required by Florida Statutes.

Any questions concerning this application package may be directed to the Application Coordinator at appcoord@floir.com. For iApply only questions, contact the Application Coordinator at iapply@floir.com

In order for a submission to be considered a complete application, all required information must be included in the filing. Filings that do not include all required information will be disapproved or returned.

Pursuant to Section 636.Part II, Florida Statutes, in order to do business as a Discount ~~Medical~~ Plan Organization (D~~M~~PO), an entity must:

A. Be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with Chapter 605, Part I of Chapter 607, ~~Chapter 608,~~ Chapter 617, Chapter 620, or Chapter 865, F.S., and must be licensed by the Office as a discount ~~medical~~plan organization or be licensed by the Office pursuant to Chapter 624, Part I of Chapter 636, or Chapter 641, F.S.
[s., 636.204(1), F.S.];

B. Be an entity, which in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. [s.636.202(2), F.S.];

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

~~**APPLICATION FOR LICENSE**~~
~~**DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)**~~

INSTRUCTIONS

SECTION I - APPLICATION FEES AND FORM

Section I-1 Application Fee

The application filing fee is $50.00. The initial fee is due and payable at the time of filing the application for licensure. [s.636.204(2)(l) and s.636.204(5), F.S.]

~~Original Check and Invoice~~
Secure the check to the invoice, which is included in this package, and send to:

Florida Department of Financial Services
~~Bureau of Financial Services~~Revenue Processing Section
P.O. Box 6100
Tallahassee, Florida 32314-6100

~~Copy of Check and Invoice~~
~~Place~~ Submit a ~~photo~~copy of the invoice and a copy of the check with your application filing. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section I-2 Fingerprint Processing Fees

Applicants are required to prepay electronically for the processing of the fingerprint cards required in Section IV-4. Please see Form OIR-C1-938 ~~REV 5/2013~~ for instructions.
~~Applicants are required to prepay electronically for the processing of the fingerprint cards required in section IV-4. Please see form OIR-C1-938 for instructions. The fingerprint cards are to be submitted with the application filing.~~
~~Place a copy of your on-line payment confirmation along with the fingerprint cards in the management section (IV-4).~~

~~NOTE:~~ Florida residents have the option of having their fingerprints digitally scanned rather than providing paper fingerprint cards. Please see form OIR-C1-938 for instructions.
~~**NOTE: Individuals who are non-U.S. citizens with no social security number should continue to submit payment of fingerprint fees per instructions in form OIR-C1-903.**~~

Section I-3 Application for License (Official Form included with this package)

This form must be sworn to by an officer or authorized representative of the applicant.

~~**APPLICATION FOR LICENSE**~~

~~**DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)**~~

SECTION II-LEGAL

Section II-1 Articles of Incorporation

Include in this section the applicant's Articles of Incorporation or other organizing documents, including all amendments. The required filings must be recently certified by the official public records custodian in the applicant's state of domicile. The certification letter must be an original. [s.636.204(2)(a), F.S.]

Section II-2 Certificate of Status from Florida Secretary of State

Provide a Certificate of Status document issued by the Florida Secretary of State which certifies that the applicant is authorized in this State and that all state taxes and fees have been paid. This certificate must be obtained from the Florida Secretary of State's office and be an original. [s.636.204(1), F.S.]

If you have any questions concerning filing with the Secretary of State, please contact the Division of Corporations at (850) 245-6051 or see http://www.sunbiz.org/.

Important note: The Secretary of State will issue a charter to a discount ~~medical~~ plan organization before the Office completes its processing of an application for a license. This charter authorizes the company to engage in any type of business except insurance or discount ~~medical~~ plans, or other regulated business.

Your company MAY NOT engage in the business of a ~~medical~~ discount plan in Florida until it has been issued a license by the Commissioner of the Office.

Section II-3 By-Laws, Constitution, or Rules and Regulations

Include a copy of the applicant's By-Laws, Constitution, and/or Rules and Regulations in this section. The bylaws must be ~~sealed,~~ signed, and recently dated by the Secretary of the company. No signature other than the Secretary's will be accepted. [s. 636.204(2)(b), F.S.]

Section II-4 Certificate of Compliance (Foreign Applicants Only)

If applicable, provide a Certificate of Compliance issued by the public official having supervision in applicant's state of domicile showing that the company is organized and authorized to issue contracts and the kinds of contracts it is authorized to transact. The certificate should be an original under seal by the organization's state of domicile. If not applicable, please state this in the application.

Section II-5 **Service of Process Form**

[s.636.234, 624.422 and 624.423 F.S.]

Provide an executed Service of Process Consent and Agreement form (official form included in this package) under corporate seal and signed by the president or chief executive officer and secretary.

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Marketing and Growth

Submit a description of the proposed method of marketing, including the target groups, types of discounts to be offered, and advertising media to be used.
[s. 636.204(2)(j), F.S.]

Section III-2 Advertising

Provide a description of the procedures in place for the D~~M~~PO to approve advertising, prior to use, pursuant to Section 636.228, Florida Statutes.

~~Please note that although advertisements are not required to be filed for prior approval, the company is required to maintain compliance with Rule 69O-203.204, which provides standards for advertisements and Rule 69O-203.205, which provides advertisement enforcement procedures.~~

Section III-3 Website

Prior to licensure by the Office, each D~~M~~PO must establish an Internet website that conforms to the requirements of Section 636.226, Florida Statutes. [s. 636.204(4)] This website should also comply with the disclosures required in s. 636.212, F.S. and should not include any prohibitions listed in s. 636.210, F.S.

Provide the address of the website that complies with these statutes.

Section III-4 Financial

A. Submit a copy of the applicant's most recent financial statements audited by an independent certified public accountant [s.636.204,(2)(i), F.S.], and provide the date of the company's fiscal year end.

B. Each D~~M~~PO must at all times maintain a net worth of at least $150,000. [s.636.220(1), F.S.]

   The OFFICE may not issue a license unless the D~~M~~PO has a net worth of at least $150,000.
   [s.636.220(2), F.S.]

C. Documentation that the applicant has complied with the surety bond or security deposit requirements [636.236(1), Florida Statutes]. For security deposits, contact the Bureau of Collateral Management at (850) 413-3167.

(1) Each D~~M~~PO must maintain in force (unless deposit is placed in lieu of the bond) a surety bond in its own name in an amount not less than $35,000 to be used at the discretion of the Office to protect the financial interest of members who may be adversely affected by the insolvency of a D~~M~~PO. The bond must be issued by an insurance company that is licensed to do business in this state.

(2) In lieu of #1 above, each D~~M~~PO shall deposit with the Bureau of Collateral Management cash or securities of the type eligible under Section 625.52, Florida Statues, which shall have at all times a market value of $35,000.

(3) If for any reason the market value of assets and securities of D~~M~~PO held on deposit in this state falls below the amount required, the organization shall promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency.

Section III-5 Contractual

A. A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members. [s. 636.204(2)(f), F.S.]

B. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health services to members. [s. 636.204(2)(h), F. S.]

C. A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in the Management Section (Section IV) of this application as individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10% or more voting securities of the applicant. [s. 636.204(2)(c) and (g), F.S.]

Section III-6 A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered. [s. 636.204(2)(e), F.S.]

Section III-7 A description of the subscriber complaint procedures to be established and maintained. [s. 636.204,(2)(k), F.S.]

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

~~**APPLICATION FOR LICENSE**~~
~~**DISCOUNT MEDICAL PLAN**~~
~~**ORGANIZATION (DMPO)**~~

SECTION IV - MANAGEMENT

NAMES REQUESTED IN THIS SECTION SHOULD INCLUDE COMPLETE FIRST, MIDDLE AND LAST NAMES.

Section IV-1 List of All Officers, Directors, and Shareholders~~Stockholders~~ [s.636.204(2)(c) F.S.]

A. List the names, addresses and official positions of each officer, director and any person having direct or indirect control of the organization, including but not limited to contracted management company personnel (form included in this package).

B. List the names of each ~~stockholder~~ shareholder owning ten percent or more of voting securities of the applicant or any person having the right to acquire ten percent or more of the voting securities of the applicant (issued and outstanding warrants/options, etc.). Such persons shall fully disclose to the Office and to the directors the extent and nature of any contracts or arrangements between them and the D~~M~~PO, including any possible conflicts of interest.

C. If the applicant is a subsidiary of a parent or holding company, provide an organizational chart showing the relationship of all related companies.

Section IV-2 Biographical Affidavits for Officers, Directors and Shareholders~~Stockholders~~ [s.636.204(2)(d),F.S.]

Provide a ~~National Association of Insurance Commissioners (NAIC) b~~Biographical ~~a~~Affidavit (Form OIR-C1-1423) for each officer, director, any person having direct or indirect control of the organization, including but not limited to contracted management company personnel and shareholder listed in Section IV-1 except for those companies in the organizational structure between the immediate parent and the ultimate parent. All questions must be answered. All “Yes” answers must be explained.

Each biographical affidavit must ~~be submitted to the Office~~ contain~~ing~~ an original signature and original notary seal. ~~If, however, the biographical affidavits are currently on file and are not more than two years old, no submission is necessary.~~

The requirement for the affiant’s social security number as part of the Biographical Affidavit is mandatory. However, pursuant to ~~s~~Sections 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from ~~s~~Section 119.07(1), Florida Statutes, and ~~s~~Section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on ~~page 6 of the NAIC for~~ the Biographical Affidavit~~m~~, please include the affiant’s name

and social security number on a separate page and attach it to the Biographical Affidavit. Also please markstamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office. The duties of the Office in background investigation are extensive in order to ensure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

Section IV-3 Investigative Background Reports [636.204(2)(d) F.S.]

~~An Investigative~~ A Background Investigative Report must be provided for each person listed in Section IV-1 above except for those companies in the organizational structure between the immediate parent and the ultimate parent. Background reports must be submitted by the selected background investigator vendor prior to or contemporaneously with the application filing. Please refer to form OIR-C1-905 REV 10/05 for instructions.

Section IV-4 Fingerprint Cards

~~Fingerprint cards must be completed for each person listed in Section IV-1 (except for those companies in the organizational structure between the immediate parent and the ultimate parent). [s.636.204(2)(d),F.S.]~~

~~The fingerprint cards along with the fees are due at the time the application is filed.~~ ~~**No cards other than those furnished by the Office will be accepted.**~~ ~~These cards must be completed at a law enforcement or similar type agency and returned to this Office for processing. Please refer to form OIR-C1-938 for instructions.~~

~~Note: Florida residents have the option of having their fingerprints digitally scanned rather than providing paper fingerprint cards and fees as noted above. Please refer to form OIR-C1-938 for instructions.~~

Fingerprint cards must be completed for each person listed in Section IV-1. The cards will be furnished by the Office upon request. **No cards other than those furnished by the Office will be accepted.** The cards must be completed at a law enforcement agency and returned to this Office for processing. Please refer to Form OIR-C1-938 ~~REV 5/2013~~ for instructions.

Florida residents have the option of having their fingerprints digitally scanned rather than providing paper fingerprint cards and fees as noted above. Please refer to Form OIR-C1-938.

~~**APPLICATION FOR LICENSE**~~
~~**DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)**~~

~~SECTION V - FORMS AND RATES~~

~~NOTE: THE COMPANY CAN SUBMIT ITS FORMS AND RATES ONLY AFTER RECEIVING A NOTICE FROM THIS OFFICE THAT THIS APPLICATION HAS BEEN ACCEPTED. FORMS AND RATES SHOULD BE SUBMITTED TOGETHER IN THE SAME FILING. THE COMPANY IS PROHIBITED FROM WRITING BUSINESS USING UNAPPROVED FORMS OR RATES.~~

~~**Section V-1 Forms**~~
~~(See Rule 69O-203.203, for Discount Medical Plan Standards)~~
~~All form filings shall be submitted to the Office electronically to https://iportal.fldfs.com~~

~~**Section V-2 Rates**~~
~~(See Rule 69O-203.204, for Discount Medical Plan Rate Standards)~~
~~All rate filings shall be submitted to the Office electronically to https://iportal.fldfs.com~~

~~**APPLICATION FOR LICENSE**~~
~~**DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)**~~

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

CHECK LIST
SECTION I - APPLICATION FEES AND FORM

Company Name: ____

Item # — Completion Check List

1. Insurer application fees paid.. ☐

   (a) Copy of invoice included (Official Form).................................... ☐

   (b) Copy of check... ☐

   ~~(c) Placed in Section I~~..(c~~d~~) ☐
   Originals mailed to Revenue Processing ~~Section~~~~Bureau of Financial Services~~.......................

2. Fingerprint fee paid electronically.. ☐

   a. Copy of on-line payment confirmation.................................... ☐

   ~~or, if applicable~~

   ~~b. Copy of form OIR-C1-903 (invoice) included........................~~ ☐

   ~~c. Copy of check included...~~ ☐

   ~~d. Originals mailed to Bureau of Financial Services.................~~ ☐

3. Application for License (Official Form).. ☐

   (a) All blanks completed.. ☐

   (b) If applicable, sealed by corporation... ☐

   (c) Signed by President or other authorized officer
   (original signature)... ☐

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

~~APPLICATION FOR LICENSE~~
~~DISCOUNT PLAN ORGANIZATION (DPO)~~
SECTION II – LEGAL

Company Name: ____

Item #		Completion Check List
1.	Articles of Incorporation or other organizing documents and all amendments attached with an original certification by the State of Domicile	☐
2.	Certificate of Status from Florida Secretary of State (original document)	☐
	(a) Good standing indicated........	☐
	(b) Sealed by state........	☐
	(c) Signed by proper public official........	☐
	(d) Original........	☐
3.	Corporate By-Laws, Rules and Regulations, and/or Constitution	☐
	(a) Signed and dated by applicant's secretary........	☐
	~~(b) If applicable, sealed by corporation........~~	☐
4.	Certificate of Compliance from State of domicile........	☐
	(a) Original Certification from State of domicile........	☐
	(b) Form indicates the kinds of contracts the company is authorized to transact........	☐
	(c) Not applicable........	☐
5.	Service of Process Form........	☐

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

~~**APPLICATION FOR LICENSE**~~
~~**DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)**~~

SECTION III - FINANCIAL AND RELATED INFORMATION

Company Name: ____

Item #		Completion Check List
1.	Marketing and growth	☐
	(a) Description of marketing methods...	☐
2.	Advertising..	☐
	(a) Include a description of advertising procedures......................	☐
3.	Provide website address	☐
4.	Financial	☐
	A. Current audited financial statements & fiscal year end date...	☐
	B. Compliance with minimum surplus requirement.....................	☐
	C. Original document evidencing compliance with surety bond requirement or security deposit requirement as explained in S.III-4C 1&2	☐
5.	Contractual Documents	☐
	(a) Provider contract form	☐
	(b) Other forms of contracts per s.636.204(2)(h), F.S.	☐
	(c) Other forms of contracts per s.636.204(2)(c) and (g), F.S.......	☐
6.	Statement describing facilities, personnel, and medical services...	☐
7.	Description of subscriber complaint procedures............................	☐

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

~~APPLICATION FOR LICENSE~~
~~DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)~~

SECTION IV – MANAGEMENT

Note: This portion of the checklist is detailed in order to assist the applicant in ensuring all items are completed, and checklist item numbers will not correlate with item numbers in the Instructions.

Item #		Completion Check List
1.	Listing of all officers, directors, and shareholders (including entities owning 10% or more of applicant (Form OIR-C1-1298)	☐
2.	Listing of all immediate parent(s) officers, directors, and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298)	☐
3.	Listing of all intermediary parent(s) (between immediate parent(s) and ultimate parent(s)), officers and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298). Note, do not complete Form OIR-C1-1423, (Biographical Affidavits) or order investigative reports or fingerprint cards............................	☐
4.	Listing of all ultimate parent(s) officers, directors, and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298)	☐
5.	Organizational Chart including all entities within the ultimate parent company structure..	☐
6.	Biographical Affidavits for company officers, directors, and shareholders (including entities) owning 10% or more of applicant (Form OIR-C1-1423)	☐
	As to each biographical:	
	(a) All blanks completed..	☐
	~~(b) "Yes" answers explained...~~	
	(b~~c~~) Contains original signature...	☐
	(c~~d~~) Notarized (original)	☐
	(d~~e~~) SSN on a separate page..	☐

SECTION IV – MANAGEMENT
Required Filing and Check list

7. Biographical Affidavits for immediate parent(s) officers, directors, and shareholders (including entities) owning 10% or more of parent Company's stock (Form OIR-C1-1423) .... ☐

As to each biographical:

(a) All blanks completed.. ☐

~~(b) "Yes" answers explained...~~ ☐

(b~~c~~) Contains original signature..

(c~~d~~) Notarized (original).. ☐

(d~~e~~) SSN on a separate page.. ☐

8. Biographical Affidavits for ultimate parent(s) officers, directors, and Shareholders (including entities) owning 10% or more of parent company's Stock (Form OIR-C1-1423)

As to each biographical:

(a) All blanks completed.. ☐

(b) ~~"Yes" answers explained...~~ ☐

~~(c)~~ Contains original signature..

(c~~d~~) Notarized (original).. ☐

(d~~e~~) SSN on a separate page.. ☐

9. Background investigative reports for company officers, directors, and shareholders (including entities) owning 10% or more of applicant.. ☐

10. Background Investigative reports for immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock.. ☐ ~~**APPLICATION FOR LICENSE**~~

11. Background Investigative reports for ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock...

Note: If fingerprints are digitally scanned, Items 12, 13 and 14 are not applicable.

12. Fingerprint cards completed~~enclosed~~ for each company officer, director, and shareholder (including entities) owning 10% or more of applicant ....

    As to each fingerprint card:

    (a) Contains original signature..

    (b) Florida cards only...

    (c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page) ....

13. Fingerprint cards completed~~enclosed~~ for each immediate parent(s) officer, director, and shareholder (including entities) owning 10% or more of parent company's stock...

    As to each fingerprint card:

    (a) Contains original signature..

    (b) Florida cards only...

    (c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page) ....

14. Fingerprint cards completed~~enclosed~~ for each ultimate parent(s) officer, director, and shareholder (including entities) owning 10% or more of parent company's stock...

    (a) Contains original signature...

    (b) Florida cards only...

    (c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page)..

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

~~APPLICATION FOR LICENSE~~
~~DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)~~

CHECKLIST VERIFICATION

The undersigned says that he/she is a senior officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with licensure sought by (Entity Name)_______________________________________ that he/she has read said application, that he/she knows the contents thereof and verifies that the items indicated in the application checklist have been submitted with the application, that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument, the applicant on behalf which the person acted, executed the instrument**.**

I understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes.

Dated ______________

(Give full and exact name of applicant)

____

____
Signature of President, Secretary, or Treasurer

____ ____
Printed Name Printed Title

~~APPLICATION FOR LICENSE~~
~~DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)~~

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

Pursuant to Chapter 636, Part II Florida Statutes, application is hereby submitted to form and operate a Discount ~~Medical~~ Plan Organization.

In order to qualify as a Discount ~~Medical~~ Plan Organization (D~~M~~PO), an entity must:

A. Be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with Chapter 60~~7~~5, part I of Chapter 607~~608~~, Chapter 617, Chapter 620, or Chapter 865, F.S., and must be licensed by the Office as a discount ~~medical~~ plan organization or be licensed by the Office pursuant to Chapter 624, Part I of Chapter 636, or Chapter 641, F.S. [s., 636.204(1), F.S.];

B. Be an entity which, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. [s.636.202(2), F.S.];

Proposed name of Discount ~~Medical~~ Plan Organization:

NAME: ____________________

ADDRESS: ____________________

CITY: ____________ STATE:______ ZIP CODE: __________

FEDERAL IDENTIFICATION NUMBER: ____________________

PHONE:____________________

CONTACT PERSON: ____________________

E-MAIL:______________ FAX:______________

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: ____________________

ADDRESS: ____________________

CITY: ____________ STATE: __________ ZIP CODE: __________

PHONE:__________ E-MAIL:__________ FAX:__________

~~**APPLICATION FOR LICENSE**~~
~~**DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)**~~

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

This company, through its duly authorized officers, hereby applies for a license authorizing and empowering it to operate as a discount ~~medical~~ plan organization in the state of Florida, under the laws thereof, and do hereby swear or affirm that all of the responses, information, exhibits, and documentary evidence submitted in support of this application are true and correct.

Signed this ____________ day of ____________________, 20_____.

____
President or other authorized officer
(Please print)

____
Signature

(Corporate Seal)

State of _________________

County of _________________

Sworn to and subscribed before me this ______day of ____________20______.

____
Notary Public

(Notary Seal)

____
My Commission Expires

~~**APPLICATION FOR LICENSE**~~
~~**DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)**~~

APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)

INVOICE
PAYMENT OF APPLICATION FEE

NAME OF COMPANY: ____

FEIN #: ____

ADDRESS: ____

CITY, STATE & ZIP CODE: ______________________________________

PHONE NUMBER:____

ADDRESS (IF DIFFERENT FROM STREET ADDRESS)

____

____
(CITY) (STATE) (ZIP CODE)

E-MAIL ADDRESS:______________________ FAX:________________________

In reference to the recent submission by the above-referenced discount ~~medical~~ plan organization regarding its application to do business in Florida, it is necessary that you return this form with the proper payment as listed below.

PLEASE NOTE:

1. Send a check in the proper amount made payable to the Florida Department of Financial Services and mail check and invoice only to the Florida Department of Financial Services, Revenue Processing Section~~of Financial Services~~, P.O. Box 6100, Tallahassee, Florida 32314-6100.

2. Include a copy of the check and invoice with the application filing submitted electronically via iApply.~~Send the original check for $50 made payable to the Florida Department of Financial Services, and mail the check and invoice to the Department of Financial Services, Bureau of Financial Services, P.O. Box 6100, Tallahassee, Florida 32314-6100.~~
   ~~Send a copy of the check and a copy of the invoice along with the completed application package to the Office of Insurance Regulation, Applications Coordination Section, 200 East Gaines Street, Larson Building, Tallahassee, Florida 32399-0332.~~

If you have any questions, please contact Applications Coordination at (850) 413-2575.

	B/T	TY/CL	F/T	AMOUNT
Filing Fee	C	1249F	F	$ 50.00

OIR-C1-1606
Rev 01/18
Rule 69O-203.210

69O-203
Rulemaking Authority

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer

and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:

1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).

2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

636.232 Rules.—The commission may adopt rules to administer this part, including rules for the licensing of discount plan organizations, providing for the collection of data, relating to disclosures to plan members, and defining terms used in this part.

636.202 Definitions.—As used in this part, the term:
(1) "Discount plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. The term does not include any product regulated under chapter 627, chapter 641, or part I of this chapter; any medical services provided through a telecommunications medium that does not offer a discount to the plan member for those medical services; or any plan that does not charge a fee to plan members. Until June 30, 2018, a discount plan may also be referred to as a discount medical plan.
(2) "Discount plan organization" means an entity that, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. Until June 30, 2018, a discount plan organization may also be referred to as a discount medical plan organization.
(3) "Marketer" means a person or entity that markets, promotes, sells, or distributes a discount plan, including a private label entity that places its name on and markets or distributes a discount plan but does not operate a discount plan.
(4) "Medical services" means any care, service, or treatment of illness or dysfunction of, or injury to, the human body, including, but not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, laboratory services, and medical equipment and supplies. The term does not include pharmaceutical supplies or prescriptions.
(5) "Member" means any person who pays fees, dues, charges, or other consideration for the right to receive the purported benefits of a discount plan.
(6) "Provider" means any person or institution that is contracted, directly or indirectly, with a discount plan organization to provide medical services to members.
(7) "Provider network" means an entity that negotiates on behalf of more than one provider with a discount plan organization to provide medical services to members.

636.204 License required.—
(1) Before doing business in this state as a discount plan organization, an entity must be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with chapter 605, part I of chapter 607, chapter 617, chapter 620, or chapter 865, and must be licensed by the office as a discount plan organization or be licensed by the office pursuant to chapter 624, part I of this chapter, or chapter 641.
(2) An application for a license to operate as a discount plan organization must be filed with the office on a form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following, if applicable:

(a) A copy of the applicant's articles of incorporation or other organizing documents, including all amendments.
(b) A copy of the applicant's bylaws.
(c) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount plan organization, including any possible conflicts of interest.
(d) A complete biographical statement on forms prescribed by the commission, an independent investigation report, and a set of fingerprints, as provided in chapter 624, with respect to each individual identified under paragraph (c).
(e) A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered.
(f) A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members.
(g) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in paragraph (c).
(h) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health services to members.
(i) A copy of the applicant's most recent financial statements audited by an independent certified public accountant. An applicant that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the subsidiary may petition the office to accept, in lieu of the audited financial statement of the applicant, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the applicant required by this part will be met by the parent entity.
(j) A description of the proposed method of marketing.
(k) A description of the subscriber complaint procedures to be established and maintained.
(l) The fee for issuance of a license.
(m) Such other information as the commission or office may reasonably require to make the determinations required by this part.
(3) The office shall issue a license which shall expire 1 year later, and each year on that date thereafter, and which the office shall renew if the licensee pays the annual license fee of $50 and if the office is satisfied that the licensee is in compliance with this part.
(4) Before licensure by the office, each discount plan organization must establish an Internet website so as to conform to the requirements of s. 636.226.
(5) The license fee under subsection (2) is $50 per year per licensee. All amounts collected shall be deposited into the General Revenue Fund.
(6) This part does not require a provider who provides discounts to his or her own patients to obtain and maintain a license as a discount plan organization.

636.208 Fees; charges; reimbursement.—
(1) A discount plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount plan.
(2)(a) If the member cancels his or her membership in the discount plan organization within the first 30 days after the effective date of enrollment in the plan, the member shall

receive a reimbursement of all periodic charges upon return of the discount card to the discount plan organization.
(b) If the member cancels his or her membership in the discount plan organization after the first 30 days, the discount plan organization:
1. Must cancel the membership on or before 30 days after receipt of the member's cancellation request.
2. May not charge the member any fees after the effective date of the cancellation of the membership.
3. Must provide a pro rata reimbursement of periodic charges made for months after the cancellation date.
(c) If the member cancels his or her membership in the discount plan organization consistent with the open enrollment rules established by an employer or association for a plan having an open enrollment period, the member shall receive a pro rata reimbursement of all periodic charges upon return of the discount card to the discount plan organization.
(3) If the discount plan organization cancels a membership for any reason other than nonpayment of fees by the member, the discount plan organization must make a pro rata reimbursement of all periodic charges to the member.
(4) In addition to the reimbursement of periodic charges for the reasons stated in subsections (2) and (3), a discount plan organization shall also reimburse the member for any portion of a one-time processing fee that exceeds $30 per year.

636.216 Written agreement.—There must be a written agreement between the discount plan organization and the member specifying the benefits under the discount plan and complying with the disclosure requirements of this part.

636.218 Annual reports.—
(1) Each discount plan organization shall file with the office, within 3 months after the end of each fiscal year, an annual report.
(2) Such reports must be on forms prescribed by the commission and must include:
(a) Audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement, and statement of changes in cash flow for the preceding year. An organization that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the organization may petition the office to accept, in lieu of the audited financial statement of the organization, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the organization required by this part will be met by the parent entity.
(b) If different from the initial application or the last annual report, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the discount plan organization, including any possible conflicts of interest.
(c) The number of discount plan members in the state.
(d) Such other information relating to the performance of the discount plan organization as is reasonably required by the commission or office.
(3) Every discount plan organization that fails to file an annual report in the form and within the time required by this section shall forfeit up to $500 for each day for the first 10 days during which the neglect continues and shall forfeit up to $1,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the office to that effect, the organization's authority to enroll new members or to do business in this state ceases while such default continues. The office shall deposit all sums collected by the office

under this section to the credit of the Insurance Regulatory Trust Fund. The office may not collect more than $50,000 for each report.

636.220 Minimum capital requirements.—
(1) Each discount plan organization shall at all times maintain a net worth of at least $150,000.
(2) The office may not issue a license unless the discount plan organization has a net worth of at least $150,000.

636.226 Provider name listing.—Each discount plan organization must maintain on an Internet website an up-to-date list of the names and addresses of the providers with which it has contracted, the address of which must be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the discount plan organization has contracted directly, as well as those who are members of a provider network with which the discount plan organization has contracted.

636.228 Marketing of discount plans.—
(1) All advertisements, marketing materials, brochures, and discount cards used by marketers must be approved in writing by the discount plan organization.
(2) The discount plan organization must have an executed written agreement with a marketer before the marketer's marketing, promoting, selling, or distributing the discount plan. Such agreement must prohibit the marketer from using marketing materials, brochures, and discount cards without the approval in writing by the discount plan organization. The discount plan organization may delegate functions to its marketers but shall be bound by any acts of its marketers, within the scope of the delegation, which do not comply with this part.

636.230 Bundling discount plans with other products.—A marketer or discount plan organization selling a discount plan with medical services and other services may commingle those products on a single page of forms, advertisements, marketing materials, or brochures.

636.234 Service of process on a discount plan organization.—Sections 624.422 and 624.423 apply to a discount plan organization as if the discount plan organization were an insurer.

636.236 Surety bond or security deposit.—
(1) Each discount plan organization licensed pursuant to this part shall maintain in force a surety bond in its own name in an amount not less than $35,000 to be used at the discretion of the office to protect the financial interests of members who may be adversely affected by the insolvency of a discount plan organization. The bond must be issued by an insurance company that is licensed to do business in this state.
(2) In lieu of the bond specified in subsection (1), a licensed discount plan organization may deposit and maintain deposited in trust with the department securities eligible for deposit under s. 625.52 having at all times a value of not less than $35,000. If a licensed discount plan organization substitutes its deposited securities under this subsection with a surety bond authorized in subsection (1), such deposited securities must be returned to the discount plan organization no later than 45 days following the effective date of the surety bond.

(3) A judgment creditor or other claimant of a discount plan organization, other than the office or department, does not have the right to levy upon any of the assets or securities held in this state as a deposit under subsections (1) and (2).

636.067 Rules.—The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this act. A violation of any such rule subjects the violator to the provisions of s. 636.048.

636.007 Certificate of authority required.—A person, corporation, partnership, or other entity may not operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the office pursuant to this act. A political subdivision of this state which is operating an emergency medical services system and offers a prepaid ambulance service plan as a part of its emergency medical services system shall be exempt from the provisions of this act and all other provisions of the insurance code. An insurer, while authorized to transact health insurance in this state, or a health maintenance organization possessing a valid certificate of authority in this state, may also provide services under this act without additional qualification or authority, but shall be otherwise subject to the applicable provisions of this act.

636.008 Application for certificate of authority.—Before any entity may operate a prepaid limited health service organization, it must obtain a certificate of authority from the office. An application for a certificate of authority to operate a prepaid limited health service organization must be filed with the office on a form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following:
(1) A copy of the applicant's basic organizational document, including the articles of incorporation, articles of association, partnership agreements, trust agreement, or other applicable documents and all amendments to such documents.
(2) A copy of all bylaws, rules, and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs.
(3) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the prepaid limited health service organization, including any possible conflicts of interest.
(4) A complete biographical statement, on forms prescribed by the commission, an independent investigation report, and a set of fingerprints, as provided in chapter 624, with respect to each individual identified under subsection (3).
(5) A statement generally describing the applicant, its facilities and personnel, and the limited health service or services to be offered.
(6) A copy of the form of all contracts made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees.
(7) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in subsection (3).
(8) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment,

investment management, and subcontracting for the provision of limited health services to enrollees.
(9) A copy of the form of any prepaid limited health service contract which is to be issued to employers, unions, trustees, individuals, or other organizations and a copy of any form of evidence of coverage to be issued to subscribers.
(10) A copy of the applicant's most recent financial statements audited by an independent certified public accountant.
(11) A copy of the applicant's financial plan, including a 3-year projection of anticipated operating results, a statement of the sources of funding, and provisions for contingencies, for which projection all material assumptions shall be disclosed.
(12) A schedule of rates and charges for each contract to be used which contains an opinion from a qualified independent actuary or a qualified employee that the rates are not inadequate, excessive, or discriminatory. If a prepaid limited health service organization does not employ or otherwise retain the services of an independent actuary, the chief executive officer of the prepaid limited health service organization must review and sign the certification indicating her or his agreement with its conclusions. If the office determines that, based upon documents filed with the office, the qualified employee is not qualified, the organization shall retain the services of a qualified independent actuary.
(13) A description of the proposed method of marketing.
(14) A description of the subscriber complaint procedures to be established and maintained as required under s. 636.038.
(15) A description of how the applicant will comply with s. 636.046.
(16) The fee for issuance of a certificate of authority as provided in s. 636.057.
(17) Such other information as the commission or office may reasonably require to make the determinations required by this act.

The office shall issue a certificate of authority which shall expire on June 1 each year and which the office shall renew if the applicant pays the license fees provided in s. 636.057 and if the office is satisfied that the organization is in compliance with this act.

M E M O R A N D U M

DATE: February 19, 2018

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Sarah Berner, Assistant General Counsel
Alyssa Lathrop, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 7, 2018
Request for Approval to Publish Repeal of
Rules 69O-203.204, .205
Assignment # 216311-17

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before February 28, 2018, and to the Financial Services Commission on March 7, 2018, with a request to approve for publication the proposed rules.

The rules are being repealed to conform to the statutory changes, implemented by Chapter 2017-112, Laws of Florida. These rules are obsolete.

Sections 636.232; 624.424(1)(c); 636.208; 636.216; 636.230, F.S., are the rulemaking authority and laws implemented for these rules.

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

Approved for signature:

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier, Commissioner
Office of Insurance Regulation

69O-203.204 Filing, Approval of DPO ~~DMPO~~ Plans, Rates and Related Forms.

Rulemaking Authority 636.232 FS. Law Implemented 624.424(1)(c), 636.208, 636.216 FS. History–New 4-7-05, Amended 5-4-06, 11-1-07, Repealed______________.

69O-203.205 Bundled Products.

Rulemaking ~~Specific~~ Authority 636.232 FS. Law Implemented 636.230 FS. History–New 5-4-06, Amended 11-1-07, Repealed_____________.

69O-203.204 Filing, Approval of DPO ~~DMPO~~ Plans, Rates and Related Forms.

(1) ~~The DMPO shall file all charges with the Office and shall file for approval by the Office each of the following before use:~~

~~(a) All Plan contracts, to be used or issued in connection with any Plan; and~~

~~(b)1. Any periodic charge for any Plan that is in excess of $50.00 per month, if the plan includes at least the following services: physician services licensed under Chapter 458 or 459, F.S., dental services, vision services, chiropractic services, and podiatric services, but does not include hospital services.~~

~~2. Any periodic charge for any other Plan, whether the Plan includes one or more services, that is in excess of $30.00 per month.~~

~~(2) Free Plans. The Plan contracts and charges of a Plan that is purchased from a DMPO and subsequently provided at no charge to individuals by an insurer, bank, credit union, or employer are exempt from paragraph 69O-203.202(1)(e) and (f), F.A.C.~~

~~(3) All filings shall be submitted to the Office electronically to http://www.floir.com/iportal.~~

~~(4) A filing shall consist of the following items:~~

~~(a) A letter explaining the type and nature of the filing. The letter shall indicate if the filing is for a new Plan, rate revision or a resubmission. If the filing is a resubmission, the letter shall indicate when the previous filing was submitted, the Florida filing number, the date of the disapproval or withdrawal and previous correspondence between the DMPO and the Office.~~

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

~~(c) The material being submitted, which may include one or more of the following:~~

~~1. Charges; or~~

~~2. Contracts, applications or other forms.~~

~~(d) Discount Medical Plan Organization Review Standards Checklist, Form OIR-B2-1607, as adopted by Rule 69O-149.022, F.A.C.~~

~~(e) Other information as indicated in Rule 69O-203.205, F.A.C., as applicable.~~

Rulemaking Authority 636.232 FS. Law Implemented 624.424(1)(c), 636.208, 636.216 FS. History–New 4-7-05, Amended 5-4-06, 11-1-07, Amended______________.

69O-203.205 Bundled Products.

~~(1) The provisions of Section 636.230, F.S., recognize that the discount medical plan may be combined together with other products. When a bundled product is sold, the~~ DPO ~~DMPO must provide the charges attributable to the discount medical plan component in writing to the member if the total monthly charges for the bundled product exceed the limits of $30.00 or $50.00 as provided in paragraph 69O-203.204(1)(b), F.A.C. Any filing of a bundled product made pursuant to Rule 69O-203.204, F.A.C., shall clearly identify the discount medical plan component separately from each other component.~~

~~(2) When the bundled product contains a product that is insurance or other regulated product, the filing shall contain the following:~~

~~(a) Identification of the licensed insurer underwriting the insurance product,~~

~~(b) Disclosure of the specific policy form number providing the underlying insurance coverage issued by the licensed insurer,~~

~~(c) Disclosure of the Florida filing log number where the insurance product was filed with the Office,~~

~~(d) A copy of the rate schedule from the insurer on insurer paper or letterhead identifying the product and rates for the coverage being bundled with the discount plan,~~

~~(e) Identification of how the discount plan applicant is applying for the insurance coverage, i.e., on the enrollment~~

~~form, complete a separate application, etc., and~~

~~(f) When the insurance coverage is provided under a group policy:~~

~~1. Identification of the group policyholder that the insurance coverage is issued to, and~~

~~2. An explanation of how the discount plan applicant is an eligible individual for coverage under the group pursuant to the group's eligibility standards.~~

~~(3) When the bundled product contains insurance or other products subject to regulation and approval by the Office, a DMPO may submit for approval a combined application. Each product that is involved in the sale of the bundled product, combined application, and the charges relating to each component of the bundled product must be filed in accordance with the laws and regulations applicable to each component.~~

Rulemaking ~~*Specific*~~ *Authority 636.232 FS. Law Implemented 636.230 FS. History–New 5-4-06, Amended 11-1-07, Amended*_____________.

69O-203.204,.205
Rulemaking Authority

636.232 Rules.—The commission may adopt rules to administer this part, including rules for the licensing of discount plan organizations, providing for the collection of data, relating to disclosures to plan members, and defining terms used in this part.

636.208 Fees; charges; reimbursement.—
(1) A discount plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount plan.
(2)(a) If the member cancels his or her membership in the discount plan organization within the first 30 days after the effective date of enrollment in the plan, the member shall receive a reimbursement of all periodic charges upon return of the discount card to the discount plan organization.
(b) If the member cancels his or her membership in the discount plan organization after the first 30 days, the discount plan organization:
1. Must cancel the membership on or before 30 days after receipt of the member's cancellation request.
2. May not charge the member any fees after the effective date of the cancellation of the membership.
3. Must provide a pro rata reimbursement of periodic charges made for months after the cancellation date.
(c) If the member cancels his or her membership in the discount plan organization consistent with the open enrollment rules established by an employer or association for a plan having an open enrollment period, the member shall receive a pro rata reimbursement of all periodic charges upon return of the discount card to the discount plan organization.
(3) If the discount plan organization cancels a membership for any reason other than nonpayment of fees by the member, the discount plan organization must make a pro rata reimbursement of all periodic charges to the member.
(4) In addition to the reimbursement of periodic charges for the reasons stated in subsections (2) and (3), a discount plan organization shall also reimburse the member for any portion of a one-time processing fee that exceeds $30 per year.

636.216 Written agreement.—There must be a written agreement between the discount plan organization and the member specifying the benefits under the discount plan and complying with the disclosure requirements of this part.

636.230 Bundling discount plans with other products.—A marketer or discount plan organization selling a discount plan with medical services and other services may commingle those products on a single page of forms, advertisements, marketing materials, or brochures.

624.424 Annual statement and other information.—

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

M E M O R A N D U M

DATE: February 22, 2018

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Sarah Berner, Assistant General Counsel
Alyssa Lathrop, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 7, 2018
Request for Final Approval to Adopt Amendments to
Rule 69O-191.029
Assignment # 216048-17

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before February 28, 2018, and to the Financial Services Commission on March 7, 2018, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on February 26, 2018.

The notice of proposed rules was published on February 2, 2018, in Volume 44, No. 23, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

The amendment updates the rule to conform with the requirements of Section 641.221(2), F.S.

Sections 641.36; 641.19(7); 641.2015; 641.221, F.S., are the rulemaking authority and laws implemented for this rule.

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

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

Approved for signature:

Alyssa Lathrop for (see attached email approval)
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

Berner, Sarah

From: Brangaccio, Anoush
Sent: Thursday, February 22, 2018 5:02 PM
To: Berner, Sarah
Cc: Lathrop, Alyssa
Subject: Re: Rules for Final Adoption

Approved.

Anoush Brangaccio

Sent from my iPhone

On Feb 22, 2018, at 4:58 PM, Berner, Sarah <Sarah.Berner@floir.com> wrote:

> Anoush,
>
> Attached for approval are Rules 69O-191.029 and 69O-150.206, F.A.C, for final adoption. Alyssa has reviewed and approved. These are to be discussed with the Commissioner at tomorrow's rules meeting for final adoption at the March FSC meeting. There have been no substantive changes since you signed off for publication in December. If these are approved, would you like Alyssa to sign the memo on your behalf?
>
> I apologize for the late notice. Please let me or Alyssa know if you have any questions or concerns.
>
> Thank you,
>
> *Sarah Berner*
> Assistant General Counsel
> Office of Insurance Regulation
> Division of Legal Services
> 200 East Gaines Street
> Tallahassee, FL 32399-4206
> (850) 413-4169 direct
> (850) 922-2543 fax
>
> <191.029 Final Approval Packet.pdf>
> <150.206 Final Approval Packet.pdf>

69O-191.029 Maintaining Eligibility for Certificate of Authority.

The HMO place of business shall be located in this state and shall be actively engaged in managed care within six months of licensure except as provided in Section 641.221(2), F.S. The HMO shall maintain a place of business, the location of which is identifiable by and accessible to the public as determined by the Office. Any HMO holding an existing Certificate of Authority which has not become operational as of the effective date of this rule shall be required to comply within one (1) year of this date.

Rulemaking ~~Specific~~ Authority 641.36 FS. Law Implemented 641.19(7), 641.2015, 641.221 FS. History–New 5-28-92, Formerly 4-191.029, Amended_________________.

69O-191.029
Rulemaking Authority

641.36 Adoption of rules; penalty for violation.—The commission shall adopt rules necessary to carry out the provisions of this part. The office shall collect and make available all health maintenance organization rules adopted by the commission. Any violation of a rule adopted under this section shall subject the violating entity to the provisions of s. 641.23.

641.19 Definitions.—As used in this part, the term:

(7) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

641.2015 Incorporation required.—On or after October 1, 1985, any entity that has not yet obtained a certificate of authority to operate a health maintenance organization in this state shall be incorporated or shall be a division of a corporation formed under the provisions of either part I of chapter 607 or chapter 617 or shall be a public entity that is organized as a political subdivision. In the case of a division of a corporation, the financial requirements of this part shall apply to the entire corporation. Incorporation shall not be required of any entity which has already been issued an initial certificate of authority prior to this date and which is not a corporation on October 1, 1985, or which is incorporated in any other state on October 1, 1985; nor shall incorporation be required on renewal of any certificate of authority by such an organization or be required of a public entity that is organized as a political subdivision.

641.221 Continued eligibility for certificate of authority.—
(1) In order to maintain its eligibility for a certificate of authority, a health maintenance organization shall continue to meet all conditions required to be met under this part and the rules promulgated thereunder for the initial application for and issuance of its certificate of authority under s. 641.22.
(2) In order to maintain eligibility for a certificate of authority, a health maintenance organization authorized under the Florida Insurance Code to exclusively market, sell, or offer to sell Medicare Advantage plans in this state shall be actively engaged in managed care within 24 months after licensure, shall designate and maintain at least one primary anti-fraud employee, and shall adopt an anti-fraud plan. The Office of Insurance Regulation may extend the period of eligibility upon written request.

MEMORANDUM

DATE: February 22, 2018

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Sarah Berner, Assistant General Counsel
Alyssa Lathrop, Chief Assistant General Counsel

SUBJECT: Cabinet Agenda for March 7, 2018
Request for Final Approval to Adopt Amendments to
Rule 69O-150.206
Assignment # 207465-17

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before February 28, 2018, and to the Financial Services Commission on March 7, 2018, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on February 26, 2018.

The notice of proposed rules was published on February 2, 2018, in Volume 44, No. 23, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

The requirements for standard, basic and limited small employer health plans were removed from the statute. The rule is being amended to conform to the statute.

Sections 624.307(1); 624.308(1); 626.9541(1)(a), (b), (e), (k), and (l); 626.9641(1); 626.9611, 627.6699(9)(d) and (12), F.S., are the rulemaking authority and laws implemented for these rules.

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

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

Approved for signature:

Alyssa Lathrop for (see attached email approval)
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

Berner, Sarah

From: Brangaccio, Anoush
Sent: Thursday, February 22, 2018 5:02 PM
To: Berner, Sarah
Cc: Lathrop, Alyssa
Subject: Re: Rules for Final Adoption

Approved.

Anoush Brangaccio

Sent from my iPhone

On Feb 22, 2018, at 4:58 PM, Berner, Sarah <Sarah.Berner@floir.com> wrote:

> Anoush,
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> Attached for approval are Rules 69O-191.029 and 69O-150.206, F.A.C, for final adoption. Alyssa has reviewed and approved. These are to be discussed with the Commissioner at tomorrow's rules meeting for final adoption at the March FSC meeting. There have been no substantive changes since you signed off for publication in December. If these are approved, would you like Alyssa to sign the memo on your behalf?
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> Thank you,
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> *Sarah Berner*
> Assistant General Counsel
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> 200 East Gaines Street
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>
> <191.029 Final Approval Packet.pdf>
> <150.206 Final Approval Packet.pdf>

69O-150.206 Marketing Communications of Benefits Payable, Losses Covered, and Premiums Payable.

(1) Deceptive Words, Phrases, or Illustrations Prohibited.

(a) through (f) No Change

~~(g) A marketing communication that is an invitation to contract and is intended to be used in the marketing of a standard, basic, or limited health benefit plan in this state must contain the disclosures stated in Section 627.6699(9)(d)1., F.S.~~

~~(h)1. A marketing communication for a plan providing benefits for either a basic or standard health benefit plan shall state clearly and conspicuously in a prominent type the kind of plan marketed.~~

~~2. A marketing communication for a health benefit plan providing limited benefits, such as specified diseases or specified accidents, shall state clearly and conspicuously in prominent type the limited nature of the plan.~~

~~3. The statement shall be worded in language identical to, or substantially similar to the following: "THIS IS A LIMITED SMALL EMPLOYER HEALTH BENEFIT PLAN", "THIS IS A BASIC SMALL EMPLOYER HEALTH BENEFIT PLAN", "THIS IS A STANDARD SMALL EMPLOYER HEALTH BENEFIT PLAN", whichever is applicable.~~

(g) ~~(i)~~ A marketing communication of a health benefit plan sold by direct response shall not use in a misleading manner the phrases, "no salesman will call", "no agent will call", "by eliminating the agent and/or commission, we can offer this low cost plan" or similar wording.

Rulemaking Authority 624.308(1), 626.9611, 627.6699(12) FS. Law Implemented 624.307(1), 626.9541(1)(a), (b), (e), (k), (l), 626.9641(1), 627.6699(9)(d)~~1., 4.~~ FS. History–New 2-25-93, Formerly 4-150.206, Amended___________.

69O-150.206
Rulemaking Authority

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

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

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

627.6699 Employee Health Care Access Act.—

(9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER OR A(d) A small employer carrier that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier is prohibited from reinsuring or continuing to reinsure any small employer health benefits plan under subsection (11) as soon as the carrier becomes a risk-assuming carrier and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. A small employer carrier that elects to cease participating as a risk-assuming carrier and to become a reinsuring carrier is permitted to reinsure small employer health benefit plans under the terms set forth in subsection (11) and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. REINSURING CARRIER.—

(12) STANDARDS TO ASSURE FAIR MARKETING.—
(a) Each small employer carrier shall actively market health benefit plan coverage, including any subsequent modifications or additions to those plans, to eligible small employers in the state. Small employer carriers must offer and issue all plans on a guaranteed-issue basis.
(b) A small employer carrier or agent shall not, directly or indirectly, engage in the following activities:
1. Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

2. Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.
(c) Paragraph (a) does not apply with respect to information provided by a small employer carrier or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.
(d) A small employer carrier shall not, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer except if the compensation arrangement provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.
(e) A small employer carrier shall not 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 practices that violate this section or s. 626.9541.
(f) A small employer carrier or agent shall not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.
(g) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.
(h) The commission may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.
(i) A violation of this section by a small employer carrier or an agent is an unfair trade practice under s. 626.9541 or ss. 641.3903 and 641.3907.
(j) If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services relating to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section.

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—
(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:
(a) Misrepresentations and false advertising of insurance policies.—Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, comparison, or property and casualty certificate of insurance altered after being issued, which:
1. Misrepresents the benefits, advantages, conditions, or terms of any insurance policy.
2. Misrepresents the dividends or share of the surplus to be received on any insurance policy.
3. Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy.
4. Is misleading, or is a misrepresentation, as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates.
5. Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof.

69O-150.206
Rulemaking Authority

6. Is a misrepresentation for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.
7. Is a misrepresentation for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy.
8. Misrepresents any insurance policy as being shares of stock or misrepresents ownership interest in the company.
9. Uses any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the insurance sales activities of any person or stands behind any person's credit or that any person, the state, or the Federal Government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person.
(b) False information and advertising generally.—Knowingly making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public:
1. In a newspaper, magazine, or other publication,
2. In the form of a notice, circular, pamphlet, letter, or poster,
3. Over any radio or television station, or
4. In any other way,
an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, which is untrue, deceptive, or misleading.

(e) False statements and entries.—
1. Knowingly:
a. Filing with any supervisory or other public official,
b. Making, publishing, disseminating, circulating,
c. Delivering to any person,
d. Placing before the public,
e. Causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public,

any false material statement.

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

(k) Misrepresentation in insurance applications.—
1. Knowingly making a false or fraudulent written or oral statement or representation on, or relative to, an application or negotiation for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual.
2. Knowingly making a material omission in the comparison of a life, health, or Medicare supplement insurance replacement policy with the policy it replaces for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual. For the purposes of this subparagraph, a material omission includes the failure to advise the insured of the existence and operation of a preexisting condition clause in the replacement policy.
(l) Twisting.—Knowingly making any misleading representations or incomplete or fraudulent comparisons or fraudulent material omissions of or with respect to any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse,

forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance in another insurer.

626.9641 Policyholders, bill of rights.—
(1) The principles expressed in the following statements shall serve as standards to be followed by the department, commission, and office in exercising their powers and duties, in exercising administrative discretion, in dispensing administrative interpretations of the law, and in adopting rules:
(a) Policyholders shall have the right to competitive pricing practices and marketing methods that enable them to determine the best value among comparable policies.
(b) Policyholders shall have the right to obtain comprehensive coverage.
(c) Policyholders shall have the right to insurance advertising and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy.
(d) Policyholders shall have a right to an insurance company that is financially stable.
(e) Policyholders shall have the right to be serviced by a competent, honest insurance agent or broker.
(f) Policyholders shall have the right to a readable policy.
(g) Policyholders shall have the right to an insurance company that provides an economic delivery of coverage and that tries to prevent losses.
(h) Policyholders shall have the right to a balanced and positive regulation by the department, commission, and office.

QUARTERLY AGENCY ACHIEVEMENT REPORT

Second Quarter of FY 2017-2018
(October 1-December 31, 2017)

Florida Office of Insurance Regulation

COST-SAVINGS

The OIR continued efforts to evaluate operations to find efficiencies within the organization and produced cost-savings by:

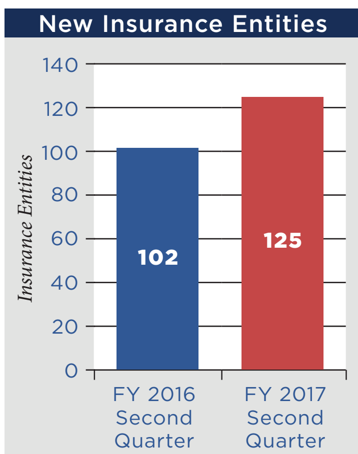
Reducing the number of employee hours by **1,543** in the last three months, a cost savings of **$38,000**.

Increasing monitoring capabilities to continue to align with new performance measures.

Reallocating resources to provide a **17% reduction** in actuarial staff.

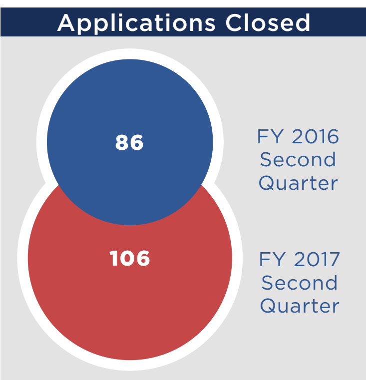
Continuing overall staff reduction efforts by decreasing staff from 315 at the peak to **289** currently.

ATTRACTING NEW BUSINESSES TO FLORIDA



The OIR increased the licensing of new insurance entities by **22%** in the second quarter of FY 2017-2018, licensing **125 entities** compared to 102 in the same quarter of FY 2016-2017.

The OIR **closed 106 applications** in the second quarter of FY 2017-2018 compared to 86 in the same quarter of FY 2016-2017, an **increase of 23%.**



The OIR saw three new Medicare Supplement carrier filings in the second quarter of FY 2017-2018. This brings the total to **five new Medicare Supplement carriers** entering the Florida market in 2017 which is an **increase of 21%** for the quarter.

FLORIDA OFFICE OF INSURANCE REGULATION

HOLDING INSURANCE COMPANIES ACCOUNTABLE

The OIR had **166 active examinations and investigations** during the second quarter of FY 2017-2018.

During the quarter, the OIR secured approximately **$37 million in policyholder refunds.**

HURRICANE IRMA

During the second quarter of FY 2017-2018, insurance companies **closed 570,498** of the 867,368 hurricane-related claims filed as of the end of the quarter.

PERFORMANCE MEASURES

							FY 2017-2018 Q2
Number	**Description**	**Weight**	**Bench-mark**	**Scale**	**Result**	**Counts**	**Score**
1	Average* number of days to process applications with a benchmark** score of 3.	8%	35.42	5 = 34.71 4 = 35.07 3 = 35.42 2 = 35.77 1 =36.13	36.61	106	1
2	Average* number of days to complete life and health form and rate filing reviews with a benchmark** score of 3.	8%	22.09	5 = 21.65 4 = 21.87 3 = 22.09 2 = 22.31 1 =22.53	22.12	1075	3
3	Average* number of days to complete property and casualty form and rate filing reviews with a benchmark** score of 3.	8%	20.90	5 = 20.48 4 = 20.69 3 = 20.90 2 = 21.11 1 =21.32	20.71	1597	3***
4	Weighted average of the percentages for completed applications/filings within: 90 days for COA's and new types of insurance; 45 days for L&H; 90 days for P&C rates and 45 days for forms; 60/90 days for priority/non-priority financial analyses; and total market conduct violations requiring remediation.	8%	100%	5 = 98 -100% 4 = 95 - 97% 3 = 92 - 94% 2 = 90 - 92% 1 = 87-89%	100.0%		5
5	Average* number of days to complete market conduct exams and investigations with a benchmark** score of 3.	8%	88.7	5 = 86.93 4 = 87.81 3 = 88.70 2 = 89.57 1 = 90.47	87.7	52	4
6	Percentage of financial exams of domestic insurers completed within 18 months of the "as of" exam date.	8%	100%	5 = 100% 4 = 98-99% 3 = 97-98% 2 = 95-96% 1 = 93 - 94%	◊		5
7	Percentage of life and health priority financial examinations of domestic insurers completed within 18 months of the "as of" exam date.	8%	100%	5 = 100% 4 = 98-99% 3 = 97-98% 2 = 95-96% 1 = 93 - 94%	◊		5
8	Percentage of property and casualty priority financial examinations of domestic insurers completed within 18 months of the "as of" exam date.	8%	100%	5 = 100% 4 = 98-99% 3 = 97-98% 2 = 95-96% 1 = 93 - 94%	◊		5
9	Average* number of days to complete priority financial analyses with a benchmark** score of 3.	8%	8.64	5 = 8.47 4 = 8.55 3 = 8.64 2 = 8.73 1 = 8.81	8.90	93	1
10	Average* number of days to complete non-priority financial analyses with a benchmark** score of 3.	8%	42.24	5 = 41.40 4 = 41.82 3 = 42.24 2 = 42.66 1 = 43.08	40.34	1435	5
						Avg.	3.7

** Average refers to an eight-quarter moving weighted average to reduce the effects of seasonality and create a stable dataset.*

*** Benchmark refers to the value of an eight-quarter moving weighted average at the end of FY 2016-2017.*

**** Rate filings affected by the Emergency Order are not reflected in this calculation.*

◊ Due to the long cycle of financial exams, none were due during the period.