FLORIDA
LAW AND ETHICS UPDATE
FL 5 – 215
An entity that is required to be licensed or registered with the Florida Office of Insurance Regulation but is operating without the proper authorization is identified as an unauthorized insurer. All persons have the responsibility of conducting reasonable research to ensure they are not writing policies or placing business with an unauthorized insurer. Any person who, directly or indirectly, aids or represents an unauthorized insurer can lose their licenses or face other disciplinary sanctions. Please see §626.901, Florida Statutes, to read the laws. Lack of careful screening can result in significant financial loss to Florida consumers due to unpaid claims and/or theft of premiums. Under Florida law, a person can be charged with a third degree felony and also held liable for any unpaid claims and refund of premiums when representing an unauthorized insurer. It is the person’s responsibility to give fair and accurate information regarding the companies they represent.
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CHAPTER 1

REGULATORY AWARENESS

It is important to keep up to date with the rules and regulations regarding the industry in which a person works, no matter what the industry. For the financial industry, it is imperative. Consumers do not generally possess the knowledge that a trained insurance professional possesses, so it is important for the consumer to feel they can rely on and trust the professional they choose to work with.

Effective October 1, 2014, agents became aware of the Department’s new continuing education requirement: A five-hour Law and Ethics Update Course pertaining to the agent’s licensure. The five-hour update course covers insurance law updates, premium discounts, ethics, disciplinary trends, industry trends and suitability of insurance products. The requirement replaced the former ethics and law course requirement; however, the five-hour update course does not satisfy specifically required continuing education courses, such as senior suitability or hurricane mitigation for compliance cycles that ended before October 31, 2014.

The five-hour update course counts toward the agent’s mandatory 24 hours and is not in addition to. Agents who hold multiple licensures need to complete one five-hour update course for at least one of the license types held. Nonresident agents and adjusters who are licensed and complete continuing education requirements in a reciprocal state are exempt from completing the five-hour course.

This course is the next installment of the required industry updates. Most of the changes we will discuss in this course occurred in the 2016 legislative session. The state legislature meets in mid-spring for a period of no more than 60 calendar days. Special sessions are called as needed.

The Florida Department of Financial Services takes strides to ease the task of “keeping up.” The Division of Insurance Agent and Agency Services provides a comprehensive website that provides licensees quick access to industry changes, updates, education information, links to the Florida Administrative Code and State of Florida Statutes, and so much more.
Throughout this course, you will be guided through the many changes that have taken place within our industry. To begin with upon completion of this first chapter, readers will be able to describe Florida’s regulatory authorities within the insurance industry in detail.

JURISDICTION OF DUTIES AND RESPONSIBILITIES

The four entities that exercise regulatory authority over insurance in the state of Florida are the state legislature, the Department of Financial Services headed by the Chief Financial Officer, the Commissioner of the Office of Insurance Regulation, and the state court system. The state legislature oversees the body of laws known as the Insurance Code, which structures the general standards for the insurance industry.

The state court system serves several purposes in the regulation of the insurance business in Florida.

- They make determinations regarding conflicts between insurance companies and policyowners;
- They enforce criminal penalties against those who violate the Insurance Code; and
- Insurance companies and agents can challenge court decisions to overturn arbitrary or unconstitutional statutes or administrative regulations or orders.

TITLE XXXVII

Title XXXVII governs Florida’s insurance laws. Florida statutes are updated annually after the conclusion of the regular legislative session and are typically published in July or August. The Governor heads Florida’s Executive Branch. The Florida Cabinet consists of the Governor, the Attorney General, the Commissioner of Agriculture, and the Chief Financial Officer.

The Department of Financial Services oversees the Financial Services Commission, which houses the Office of Financial Regulation and the Office of Insurance Regulation. All four members of the Cabinet—the Governor, the Attorney General, the Chief Financial Officer and the Commissioner of Agriculture govern the Financial Services Commission.
The Chief Financial Officer (often referred to as the “Treasurer”) heads the Department of Financial Services and is responsible for overseeing Florida’s finances, collecting revenue and paying state bills, just to name a few. The CFO has the power to investigate insurance companies and producers, settle and approve accounts against the state, and keep all state funds and securities. The CFO also serves as Florida’s State Fire Marshal and retains the power to issue cease and desist orders and to impose penalties upon those who violate the Insurance Code.

The CFO is elected to serve a four-year term and the office is subject to re-election. Two Deputy Chief Financial Officers and a Chief of Staff assist the CFO. The CFO can, at his or her discretion, also appoint an Assistant Chief Financial Officer to act in his or her stead when called upon.

Florida’s Chief Financial Officer:

- Oversees the state’s accounting and auditing functions and unclaimed property;
- Monitors the investment of state funds;
- Manages the state’s deferred compensation and risk management programs;
- Handles insurance consumer services;
- Is responsible for the licensing and oversight of insurance agents and agencies;
- Regulates funeral homes and cemeteries;
- Oversees insurance fraud investigations; and
- Ensures businesses have workers’ compensation coverage in place for employees, and assists injured workers with benefit payments and re-employment.

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1Chapter 17
THE DEPARTMENT OF FINANCIAL SERVICES

The Florida Department of Financial Services was passed into law in 1998 and became an effective authority in January 2003, combining the former offices of the Department of Insurance, Treasury and State Fire Marshal, and the Department of Banking and Finance. DFS oversees the insurance industry within the state—insurance, banking, securities, mortgage lending, and funeral and cemetery businesses. The entire spector of the Department consists of 14 divisions and several specialized offices. Following is a list of these divisions and support offices and a brief description of their duties.

- **Division of Accounting and Auditing** — Safeguards public assets, settles the state’s financial obligations, reports financial information and improves accountability.
  - Bureau of Unclaimed Property
  - Office of Fiscal Integrity
- **Division of State Fire Marshal** — Conducts code enforcement and inspection activities in relation to fire standards and safety. Investigators are sworn law enforcement officers.
- **Division of Risk Management** — Ensures that participating state agencies receive technical assistance in managing risk, and quality workers' compensation, liability, federal civil rights, automobile liability, and property insurance coverage at reasonable rates by providing self-insurance, purchase of insurance and claims administration.
- **Division of Treasury** — Operates a cash management system, administers the receipt and disbursement of state funds, invests excess funds and pays all state obligations as directed by the Division of Accounting and Auditing.
  - Bureau of Deferred Compensation
- **Division of Insurance Fraud** — Responsible for investigating all types of insurance fraud with six regions throughout the state.

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2 624.302-624.352
3 20.121
• **Division of Rehabilitation and Liquidation** — Serves as Receiver of any insurer placed into receivership within the state.

• **Division of Insurance Agents and Agency Services** — Regulates individual and agency licenses.
  - Bureau of Licensing
  - Bureau of Investigations

• **Division of Consumer Services** — Serves as the information portal to consumers in regard to all insurance matters, including a consumer help line, health reform and senior services.

• **Division of Workers’ Compensation** — Provides workers’ compensation information for employers, insurers, employees and providers.

• **Division of Funeral, Cemetery, and Consumer Services** — Regulates the entire death care industry, including protecting purchasers of pre-need burial rights and contracts, maintenance of cemetery grounds, and establishes minimum qualifications for entry into the professions and occupations of embalming, funeral directing, cremation and direct disposition.

• **Division of Public Assistance Fraud** — Safeguards the public and businesses against acts of public assistance fraud and the resulting impact by enforcing federal and state criminal laws in relation to eligibility for public assistance.

• **Division of Administration** (Support Division) — Provides administrative support for DFS, OFR and OIR.
  - Bureau of Human Resource Management
  - Bureau of General Services
  - Bureau of Financial Services
  - Office of Publications

• **Division of Legal Services** (Support Division) — Provides legal counsel and representation to the CFO and DFS.

• **Division of Information Systems** (Support Division) — Plans, manages, and operates the IT resources for DFS, OFR and OIR.
The Department furnishes all forms that are required in connection with agent licensing forms, including license applications, terminations of licenses and appointments. Forms are available on the Division of Insurance Agent and Agency Services website at www.myfloirdacfo.com/Division/Agents/Licensure/Forms.

THE FINANCIAL SERVICES COMMISSION

Effective January 7, 2003, the Department created the Financial Services Commission, which is composed of the Governor, the Attorney General, the CFO and the Commissioner of Agriculture. The Commission’s purpose is to safeguard the public by regulating the banking, securities and insurance industries.

Within the Commission, the Office of Insurance Regulation (OIR) and the Office of Financial Regulation (OFR) were established. Though these two offices are administratively housed within the Department of Financial Services, they report directly to the Commission.

THE OFFICE OF INSURANCE REGULATION

The Commissioner of Insurance Regulation heads the OIR. OIR regulates insurance companies and is entrusted with the duty of monitoring statewide industry markets. OIR is responsible for all activities concerning insurers and other risk bearing entities, including:

- Licensing and rates,
- Policy forms,
- Market conduct,
- Claims,
- Issuance of Certificates of Authority,
- Solvency,
- Viatical settlements,
- Premium financing, and
- Administrative supervision.

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4 20.121(3)
5 20.121
OIR’s Mission Statement is:

“...to ensure that insurance companies licensed to do business in Florida are financially viable, operating within the laws and regulations governing the insurance industry; and offering insurance policy products at fair and adequate rates which do not unfairly discriminate against the buying public.”

**THE OFFICE OF FINANCIAL REGULATION**

The Commissioner of the Office of Financial Regulation heads the OFR, which replaced the former Comptroller’s Office. OFR’s mission is to provide regulatory oversight for Florida’s financial services providers and is responsible for regulating Florida’s banking, finance and securities industries.

OFR’s Mission Statement is:

“...to protect the citizens of Florida, promote a safe and sound financial marketplace, and contribute to the growth of Florida’s economy with smart, efficient and effective regulation of the financial services industry.”

The Bureau of Financial Investigations is housed within the OFR. The Bureau is responsible for conducting investigations to aid in the enforcement of regulations within the state as well as out of state. If the Bureau has reason to suspect or believe that any criminal law has been violated, the office will refer any gathered records to state or federal law enforcement or prosecutorial agencies and will provide investigative assistance to those agencies as required.

**LICENSING REQUIREMENTS**

The solicitation of insurance is defined as:

“...the attempt to persuade any person to purchase an insurance product by:

1. Describing the benefits or terms of insurance coverage, including premiums or rates of return;
2. Distributing an invitation to contract to prospective purchasers;
3. Making general or specific recommendations as to insurance products;
4. Completing orders or applications for insurance products;

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6 20.121
7 626.112(1)(b)
5. Comparing insurance products, advising as to insurance matters, or interpreting policies or coverages; or

6. Offering or attempting to negotiate on behalf of another person a viatical settlement contract.

Applicants for licensure must file with the Department a written application, completed under oath and signed by the applicant, have completed any prelicensing requirements, have been electronically fingerprinted, and have paid all applicable fees to the Department. License filing fees are not subject to refund.8

- Application fee – $50
- State examination fee – $42
- Fingerprint(s) (paid to fingerprinting vendor) – $45.80
- License ID – $5
- Appointment (resident and nonresident*) – $609

*Note: An additional $6 per/county fee must be paid for every county in which a nonresident agent intends to physically transact insurance.

The Department will not grant or issue a license to any individual found to be untrustworthy or incompetent. An applicant is required to:

- Be a natural person of at least 18 years of age;
- Be a U.S. citizen or legal alien who possesses work authorization from the U.S. Bureau of Citizenship and Immigration Services and a bona fide resident of the state;
- Take and pass the required license examination;* and
- Be qualified as to knowledge, experience, or instruction in the business of insurance.10

*Note: On January 1, 2014, the examination for Life and Annuity (2-14) licensure became available in Spanish.

License applications contain a statement that must be answered as to whether the applicant has been refused or has voluntarily surrendered or has had

8 626.171(5)
9 624.501
10 626.785(1)
suspended or revoked a license to solicit insurance by the Department or by the supervising officials of any state.\(^{11}\)

Any person or entity that knowingly participates in the sale of insurance products without proper licensure according to state regulations is subject to a third-degree felony conviction. Conviction of a felony of the third degree is punishable by up to five years imprisonment and a fine up to $5,000.

An individual who is licensed in one line of insurance may not conduct the sale of insurance products that is not contained within that line of licensure; e.g., a person licensed as a life, health and variable annuity only agent is prohibited from conducting the sales of auto insurance or any other property and casualty insurance, and vice versa.

An insurance license is perpetual in the state of Florida as long as the licensee remains in good standing, his or her license has not been suspended or revoked and the licensee completes the state’s continuing education requirements.

**RESPONSIBILITIES OF THE FL 2-15 LIFE, HEALTH & VARIABLE ANNUITY AGENT**

The FL 2-15 agent license allows representation of an insurer as to life insurance and annuity contracts, including agents appointed to transact life insurance, fixed-dollar annuity contracts, or variable contracts by the same insurer—Annuity contracts including, but not limited to, fixed or variable annuity contracts; the granting of endowment benefits, additional benefits in event of death or dismemberment by accident or accidental means, additional benefits in event of the insured’s disability; and optional modes of settlement of proceeds of life insurance—Representing a health maintenance organization or, as to health insurance only, an insurer transacting health insurance; insurance against loss through sickness or accidental bodily injury.

**LICENSING EXAMINATION**

PearsonVUE is the Department’s examination vendor. Successful completion of the licensing exam does not entitle the individual for licensure—passing individuals still need to apply for licensure through the Department. Application can be completed through the MyProfile account. A passing grade is valid for one

\(^{11}\) 626.171(2)(c)
year. If more than one year has elapsed since receipt of a passing grade, the exam will have to be retaken. Please note that changes have been made in regard to retaking an examination. Applicants now are prohibited from taking an examination for any license type more than five times in a rolling twelve-month period.

Examinations are typically administered six days a week at a local PearsonVUE testing center. Test sites, times of operation, examination scheduling guidelines, candidate handbooks, examination content outlines and more are listed on PearsonVUE’s website at www.PearsonVue.com/fl/insurance/*. Special consideration will be given to applicants with disabilities by contacting PearsonVUE directly.

*Note: Any person interested in obtaining any Florida insurance license is encouraged by both the Department and PearsonVUE to read the free candidate handbook, which contains pertinent information relating to examination requirements.

It is no longer necessary to take and pass a licensing examination before applying to the Department for a license. Candidates can now apply for the license first, wait for the Department to approve the application and then take the examination. Candidates must first apply to the Department through their MyProfile account. Once the Department has reviewed and approved the application, the applicant will receive an email from the Department that instructs the applicant to log into their MyProfile account to view their examination instructions. Within two days after the applicant successfully passed the examination, the Department will send the new licensee an email instructing him or her to log into the MyProfile account to print their license.

Licensees are not required to file another application or take another exam once a license has been issued unless the licensed individual fails to procure appointment within 48 months of licensure. There is an exception to this rule, however. If the appointment was not obtained due to military service, the application period may be extended to 12 months following the date of discharge from military service—if the service does not exceed three years.12

Previously, license applicants were unlimited in the number of times they could take a licensing exam. New regulations state that applicants are now limited to five times within any 12-month period for the same license type.

12 626.181
**LAW ENFORCEMENT RECORDS**

Fingerprinting is mandatory for almost all licenses, registrations and certifications issued through the Department. Once an applicant’s fingerprints have been submitted, they are electronically submitted to the Florida Department of Law Enforcement for a criminal history check. The results of the applicant’s criminal check are subsequently forwarded to the Department.

New changes concern failure to accurately and truthfully answer the Department’s questions about an applicant’s Law Enforcement Record (“Record”). An applicant is responsible for the accuracy of all information contained in any application submitted, whether personally submitted or through a third party, including documents or information related to the applicant’s Record. (Previously, third party applications were not permitted.)

The amendments include administrative penalties and periods of disqualification for failure to truthfully and accurately answer application questions or requests regarding the Record. An applicant who fails in this requirement will be deemed guilty of material misrepresentation or material misstatement. In that case, the Department will deny the application and impose a disqualification period of one year before the applicant may reapply for or be granted any licensure. The disqualification period will begin the later of: (1) The date of the initial application or (2) the end of any disqualification period based on the criminal history of the applicant. As an alternative to the one-year disqualifying period, the applicant may elect to pay an administrative penalty of $1,500.

If the Department discovers that an applicant failed to accurately and truthfully answer any question relating to the Records after a license has been granted, the Department will suspend or revoke each license currently held by that licensee.

Certain felonies will result in permanent disbarment. Any applicant who has committed any of the following will be permanently disbarred from applying for licensure:

- A felony of the first degree,
- A capital felony,
- A felony involving money laundering, fraud or embezzlement, or

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13 69B-211.042
• A felony directly related to the financial services business.

**REQUIRED DOCUMENTATION**

If, during the application process, the Department requests that an applicant submit documentation related to the applicant’s Law Enforcement Record, the applicant will be required to furnish the following documents to the Department:

• A copy of the police arrest affidavit or arrest report or similar document for all arrests;

• A certified true copy of the charging document, such as an information indictment or ticket;

• A certified true copy of the plea, judgment and sentence; and

• A certified true copy of the order of entry into pre-trial intervention, where applicable, and the order of termination of pre-trial intervention showing dismissal of the charges.

If the requested documentation cannot be obtained because the document no longer exists, the applicant must supply a certified or sworn statement signed by a representative of the agency that would have been the custodian of the documentation indicating that the documents cannot be produced and the reason why, such as the record was lost, damaged or destroyed.

**APPOINTMENT**

“Appointment” means the authority given by an insurer or employer to a licensee to transact insurance or adjust claims on behalf of an insurer or employer.15

“No person may be, act as, or advertise or hold himself or herself out to be an insurance agent, insurance adjuster, or customer representative unless he or she is currently licensed by the Department and appointed by an appropriate appointing entity or person.”16

Only those insurance lines for which an appointing entity is so authorized can be sold by appointed licensees—and only for the products in which the agent is

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14 69B-211.004, 211.005, 211.007 F.A.C.
15 626.015(3)
16 626.112
licensed. Except with respect to a limited license as a credit insurance agent, the license of a life agent covers all classes of life insurance business. Except with respect to a **limited license** as a travel insurance agent, the license of a health agent covers all kinds of health insurance and may not be limited to a particular class of health insurance.\(^\text{17}\) Appointment applications are submitted electronically through the Florida Department of Financial Services Producer Appointment System (eAppoint). By appointing a licensee and paying the appointment fee, the appointing entity is certifying that the licensee has the necessary training to hold himself or herself out as an insurance representative and that the entity is willing to be bound by the acts of the licensee within the scope of his or her employment.

Appointments must be submitted to the Department on a monthly basis no later than 45 days after the date of appointment and appointments become effective on the date requested on the appointment form.\(^\text{18}\) The appointment continues in force until suspended, revoked, or otherwise terminated, but is subject to a renewal request filed in the appointee’s birth month and every 24 months thereafter, accompanied by payment of the renewal appointment fee.\(^\text{19}\)

Failure to notify the Department during the required time period can result in the appointing entity being assessed a delinquent fee of $250 per appointee, for which the entity is solely responsible.\(^\text{20}\)

If a currently licensed individual has been actively producing and is not properly appointed, the Department will make adjustments accordingly. If the Department deems that the appointment failure was an inadvertent error, the Department may authorize the appointment as long as all fees and taxes which would have been due for that time period had the applicant been so appointed are paid.

If a customer representative has been working for an agency without an appointment, the agency should retroactively appoint the representative back to the date he or she first started working at the agency. The agency will need to do this through their *MyProfile* account and complete Form DFS-H2-1105, *Affidavit*

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\(^{17}\) 626.311(2)(3)  
\(^{18}\) 626.371  
\(^{19}\) 626.381, 626.461  
\(^{20}\) 626.371
of Insurance Activity While Not Properly Appointed. The form can be obtained through the Division of Insurance Agent and Agency Services website.\(^{21}\)

An agent can be appointed by multiple entities as long as he or she is licensed to conduct business on behalf of those appointing entities. The Department may issue a single appointment covering both life and health insurances to those individuals who are licensed in both life and health. Before performing the functions of a viatical settlement broker, an agent must appoint himself or herself.\(^{22}\) Self-appointment can be performed through the MyProfile account.

Appointing entities are prohibited from paying commissions to an agent until the Department has approved the appointment. Appointees cannot use any supplies such as company forms, applications or stationery if such supplies relate to a class of business for which the agent is not licensed. Licenses and appointments are non-transferable. One agent cannot write business on behalf of another agent whose appointment has expired or has been terminated. Violations can subject both the entity and the agent to civil liability penalties.\(^{23}\)

Appointing entities may terminate appointments of any of its appointees at any time. Unless the termination affects the appointee’s license, which would cause license suspension or revocation, the entity must give the appointee at least 60 days’ advanced written notice and notify the Department within 30 days providing the reason for termination.\(^{24}\) If a licensed individual’s appointment expires, the licensee must not engage in any activity that requires an appointment. The Department will notify the licensee that his or her eligibility for appointment will expire unless he or she is appointed prior to expiration of the 48-month period mentioned earlier.\(^{25}\)

If an appointing entity finds that one of their appointees has pled guilty or nolo contendere or has been found guilty of a felony, the entity must notify the Department in writing within 15 days. (If a licensee is convicted of a felony and the licensee requests a hearing from the Department, the only question at issue would be if the conviction were truly valid.)

\(^{21}\) The Pulse, Vol. 3, No. 1, January 2012
\(^{22}\) 626.331, 626.341
\(^{23}\) 626.342, 626.441
\(^{24}\) 626.471, 626.511
\(^{25}\) 626.431
CONTACT INFORMATION

It is the licensee’s responsibility to notify the Department, in writing, of any changes to the licensee’s name, residence address, mailing address, email address, principal business street address and/or mailing address, and contact telephone numbers (including business numbers). The Department will immediately terminate the licensee’s license(s) and all appointments if the licensee changes his or her principal residence and/or principal place of business out of the state of Florida. Failure to notify the Department within 30 days* of any of these changes can result in fines and possible license suspension—Up to $250 for a first offense; and for any subsequent offense, a fine of at least $500 or suspension or revocation of the license.

*Note: The previous requirement was within 60 days.

If an agent is affiliated with an entity and conducting insurance business under that entity’s name, the agent has 30 days after an initial transaction of insurance to notify the Department of the entity’s particulars, including the entity’s business name and associated addresses and the names and social security numbers of each officer and director.

If an insurance agency changes its name, address, or officers or personnel within the agency, they have 30 days to notify the Department. In fact, any change from the original application must be reported within 30 days.

INSURANCE AGENCY LICENSING

If an agency is required to be licensed but fails to file the appropriate application for licensure, an administrative penalty of up to $10,000 may be imposed.

The license of an insurance agency may continue in force until canceled, suspended, or revoked, or until it is otherwise terminated or expires by operation of law.

A branch place of business that is established by a licensed agency is considered a branch agency and is not required to be licensed as long as it transacts business under the same name and federal tax identification number as the licensed agency. A licensed agent in charge must be designated at the branch location and the branch’s address and telephone number must be

26 626.541, 626.551
submitted to the department for inclusion in the licensing record of the agency within 30 days after insurance transactions begin at that location.

**WORKING OUT OF THE AGENT’S HOME**

An agent who is operating independently out of his or her residence from which consumers can conduct insurance transactions and inquiries is also required to obtain an agency license. In order to determine if an agent’s home qualifies as engaged in the conduct of insurance business, the Department will consider such factors as:

- The advertising used by the agent that includes the agent’s residence address;
- Whether there is a sign at the agent’s residence promoting the agent’s business; and
- Whether the agent meets clients in the home regularly or as a standard practice of business.

**AGENT IN CHARGE**

An “agent in charge” is the licensed and appointed agent who is responsible for the supervision of all individuals within an insurance agency location, regardless of whether the agent in charge handles a specific transaction or deals with the general public in the solicitation or negotiation of insurance contracts or the collection or accounting of moneys.

Each agency is required to appoint a licensed agent in charge. An agent in charge is limited to the following full-lines license types.

- General Lines (2-20)
- Life (2-16)
- Life including Variable Annuity (2-14)
- Health (2-40)
- Health and Life (2-18)
- Life and Health including Variable Annuity (2-15)

An agent in charge of an insurance agency is accountable for wrongful acts, misconduct, or other violations committed by the licensee or agent or by any person under his/her supervision while acting on behalf of the agency. The agent will not be held criminally liable for an act unless the agent in charge personally
committed the act or knew or should have known of the act and of the facts constituting the violation.

It is not necessary for each agency location to have a separate agent in charge under some circumstances. The same agent can act as full time agent in charge of multiple locations as long as insurance activities requiring licensure as an insurance agent do not occur at any location for which the agent is not physically present.27

An insurance agency that is owned and operated by a single licensed agent conducting business in his/her individual name and not employing or otherwise using the services of or appointing other licensees is exempt from these requirements.

The designation of the agent in charge may be changed at the option of the agency. If the agent in charge is terminated and a new agent in charge is designated, the agency must notify the Department within 30 days. If the agency does not designate another agent in charge within 90 days, the agency license will automatically expire on the 91st day from the date the designated agent in charge ended his/her affiliation with the agency.

**AGENCY NAMES**

Agency names are subject to the Department’s approval. Barring the use of an individual’s name, the Department can deny:

- A name that interferes with or is too similar to a name already filed and in use by another agency;
- A name that misleads the public in any way; or
- A name that states or implies that the agency is an:
  - insurer, motor club, hospital service plan, state or federal agency, charitable organization, or entity that primarily provides advice and counsel rather than sells or solicits insurance, or is entitled to engage in insurance activities not permitted under licenses held or applied for.28

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27 626.747  
28 626.602
LICENSE TRANSFER

If an agent is living in another state and planning on relocating to Florida, he or she can file for a license transfer with the Department. As long as the transfer licensee is in good standing in the other state and has been licensed for at least one year in that other state, the Department will consider the application based upon the same lines of authority. The application must be filed with the Department within 90 days once the licensee establishes Florida residency.29

If, as part of the licensing procedure, the reciprocal state required the licensee to successfully complete prelicensing education requirements that are equal to Florida’s prelicensing education requirements, the transfer licensee is exempt from having to complete Florida’s prelicensing course. Even if the prelicensing requirement is waived, applicants are not exempt from having to take and pass the applicable exam(s) unless the applicant holds the CLU designation.

States with full reciprocity with respect to the waiver of prelicensing course requirements when applying for resident Life, Health and Variable Annuity are: Alaska, Arizona, California, Colorado, Connecticut, Delaware, Idaho, Illinois, Indiana, Iowa, Kansas, Maine, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, South Dakota, Utah and Wyoming.

The applicant (transfer licensee) must complete and submit an application to the Department and provide certification from the other state that the applicant was in good standing at the time the license was canceled in that state. The applicant must also comply with the Department’s fingerprinting procedures.

- **MUST become a Florida resident**
- **MUST have held a valid resident license for one (1) year prior to application**
- **MUST submit the application and appropriate fees within ninety (90) days**
- **MUST submit a set of fingerprints**

If the applicant does not meet all of these requirements he or she must qualify as a first-time applicant, which means meeting the prelicensing prerequisite and passing any required state examination.

As soon as the licensee is approved and appointed by the Department, he or she may participate in the active business of insurance solicitation and sales.

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29 626.292
The Division of Insurance Agent and Agency Services signed an agreement of reciprocity with Puerto Rico for property, casualty, surplus lines, life, health/disability and variable annuity.

**Note:** Transfer of license rules apply to agents and do not include customer representatives, limited customer representatives, service representatives or bail bond agents.

**LICENSE SURRENDER**

To voluntarily surrender a license, the licensee must send a letter to the Bureau of Licensing, which includes:

- The licensee’s name,
- Florida license ID number,
- Mailing address,
- Telephone number, and
- The licensee’s signature.

The licensee must enclose their Florida insurance license ID or a statement indicating that they do not have the ID.

**GROUNDS FOR REFUSAL, SUSPENSION, OR REVOCATION**

All licenses remain the property of the state of Florida and are subject to suspension, revocation, expiration or termination. An agent’s appointment continues in force until suspended, revoked or terminated. Florida statutes outline the conditions upon which an application or license can be suspended or revoked by the Department.

An individual who fails to maintain an appointment writing the class of his or her licensure during any 48-month period will not be granted an appointment for that class of insurance until he or she qualifies as a first-time applicant.

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30 626.661
31 626.431
**INSURANCE AGENT LICENSE**

Section 626.611 – Grounds for **compulsory** refusal, suspension, or revocation of agent’s, title agency’s, adjuster’s, customer representative’s, service representative’s, or managing general agent’s license or appointment.

Section 626.621 – Grounds for **discretionary** refusal, suspension, or revocation of agent’s, adjuster’s, customer representative’s, service representative’s, or managing general agent’s license or appointment.

**Following is a list of the kinds of activities conducted by an agent that may result in refusal, revocation or suspension of an agent’s license:**

- Lack of one or more of the qualifications for license or appointment;
- Violation of any ruling by the CFO or provisions governing insurance—Knowingly aiding, assisting, procuring, advising or abetting any person in the violation of any provision of the Insurance Code;
- Failure to comply with Florida’s prelicensing and continuing education requirements—Cheating on a license examination or violating test center or examination procedures;
- Participating in unlawful rebating tactics or unlawfully sharing commissions with another;
- Violation of the provision against twisting;
- Material misstatement, willful misrepresentation or fraud in regard to an insurance policy, annuity contract or through the conduct of insurance business, including advertising;
- Demonstrating a lack of fitness or trustworthiness, or demonstrating inadequate knowledge and technical competence necessary to conduct insurance business;
- Obtaining or using a license for the sole purpose of controlled business;
- Deception or fraud in connection with an insurance transaction;
- Sale of an unregistered security;
- Representing, aiding or abetting an unauthorized insurance entity;

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32 626.611, 626.621
- Fraudulent or dishonest practice in submitting an application for workers’ compensation coverage containing false or misleading information as to employee payroll or classification to avoid or reduce the premium;

- Having been found guilty of or having pleaded guilty or nolo contendere to a felony or a crime punishable by imprisonment of one year or more which involves moral turpitude, without regard to whether a judgment of conviction has been entered;*

- Any cause for which issuance of the license or appointment could have been refused;

- Failure or refusal upon demand to pay to an insurer money held in trust and belonging to the insurer;

- Engaging in unfair methods of competition or in unfair or deceptive acts or practices; or having otherwise shown himself or herself to be a source of injury or loss to the public;

- Willful overinsurance of any property or health insurance risk;

- Code of Ethics violation;

- In transactions related to viatical settlement contracts:
  - commission of a fraudulent or dishonest act,
  - no longer meeting the requirements for initial licensure,
  - having received a fee, commission or other consideration for viatical settlements that involved unlicensed viatical settlement providers or persons who were not licensed life agents, or
  - dealing in bad faith with viators; and

- Failure to comply with any civil, criminal or administrative action taken by the child support enforcement program under the Social Security Act to determine paternity or to establish, modify, enforce or collect support.

Once the Department suspends, revokes, or refuses to renew or continue one license of a licensee, the Department will at the same time suspend or revoke all other licenses, appointments, or status or eligibility held by that licensee.33

*Case Report — A recent example of an Order of Revocation based on this type of conduct came about in January 2014 involving a licensee who pled guilty to possession of methamphetamine, hydrocodone, and tampering with physical

33 626.651
evidence—all felonies—a violation of §626.611(14). An Administrative Complaint was issued against the credit life and disability agent, which she failed to respond to. Her license and appointment was subsequently revoked for the mandatory period of two years.  

Penalties for violations of §626.621 have been changed effective March 24, 2014, through Rule 69B-231.090—penalties ranging from a three- to nine-month license suspension (including in some cases re-examination) to license revocation, depending upon the infraction.

**Insurance Agency License**

Section 626.6115 – Grounds for **compulsory** refusal, suspension, or revocation of insurance agency licensure.

Section 626.6215 – Grounds for **discretionary** refusal, suspension, or revocation of insurance agency license.

**Following is a list of the kinds of activities conducted by an insurance agency that may result in refusal, suspension or revocation of an agency license:**

- Lack of one or more of the qualifications for licensure;
- Material misstatement, misrepresentation or fraud in obtaining the license or in attempting to obtain the license;
- Denial, suspension or revocation of a license to practice or conduct any regulated profession, business or vocation relating to the business of insurance by this state, any other state, any nation, any possession or district of the United States, any court, or any lawful agency thereof; failure to take corrective action or report a violation to the Department within thirty (30) days after an individual licensee’s violation is known or should have been known by one or more of the partners, officers, or managers acting on behalf of the agency. However, the existence of grounds for administrative action against a licensed agency does not constitute grounds for action against any other licensed agency, including an agency that owns, is under common ownership with, or is owned by, in whole or in part, the agency for which grounds for administrative action exist;

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34 Case 139238-13-AG  
35 626.6115, 626.6215
• Having been found guilty of, or having pleaded guilty or nolo contendere to, a felony relating to the business of insurance or an insurance agency, without regard to whether a judgment of conviction has been entered by the court having jurisdiction;
• Knowingly employing any individual for the purposes of conducting insurance business who has had his or her license suspended or revoked;
• Misappropriation, conversion or unlawful withholding of moneys belonging to insurers or insureds or beneficiaries or to others and received in the conduct of business under the license;
• Participating in unlawful rebating tactics or unlawfully sharing commissions with another;
• Material misstatement, willful misrepresentation or fraud in regard to an insurance policy, annuity contract or through the conduct of insurance business, including advertising;
• Violation of any ruling by the CFO or provisions governing insurance or any provision of the Insurance Code;
• Failure or refusal upon demand to pay to an insurer he or she represents any money held and belonging to the insurer;
• Violation of the provision against twisting;
• Engaging in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of business under the license;
• Willful overinsurance of any property insurance risk; and
• Fraudulent or dishonest practices in the conduct of business arising out of activities related to insurance or to the insurance agency.

The grounds for compulsory refusal, suspension or revocation of insurance agency license extend to the agency’s majority owner, partner, manager, director, officer or any other person who manages or controls the agency.

**Duration of Suspension or Revocation**

If the Department finds reason for suspension or revocation of a license or appointment, the Department will specify the term of suspension—up to two

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36 626.641, 626.691, 626.6515
years. Prior to expiration of the suspension period, the license, appointment or eligibility may be modified or rescinded by the Department, through the process of application and approval for reinstatement. However, if the Department finds that the original reason for the suspension, revocation or eligibility still exists or is likely to recur, the application for reinstatement will be denied.

The same holds true in the case of application for an additional license or appointment. If one license is suspended, an additional line of authority may not be applied for within two years from the effective date of suspension. An applicant for another license or appointment must apply and qualify for licensure in the same manner as a first-time applicant. The Department may also place the offender on probation for a period up to two years, during which time the offender must comply with all terms and conditions ordered by the Department.

In the case of a second suspension, the Department may also subject the licensee to a waiting period and successful completion of continuing education courses.

If the suspension or revocation has occurred as a result of controlled business,* the Department will refuse to grant or issue any new license or appointment. In addition, if the suspension or revocation occurred as a result of solicitation or sale of an insurance product to a senior, the Department will refuse to grant or issue any license.

*Controlled business is insurance written by an agent on his or her own interests or those of his or her family or of any firm, corporation, or association with which he or she is associated, directly or indirectly, or in which he or she has an interest. A violation of the controlled business law occurs if aggregate commissions in addition to any other compensation accruing in favor of a licensee on the controlled business written exceeds or will exceed 50% of the total commissions earned by the licensee during any 12-month period.

Any licensed individual who knowingly participated in the action that led to the suspension or revocation may also be subject to the same disciplinary action. In addition, if the suspension or revocation is levied upon an insurance agency, any affiliated offices or agencies will be subject to the same disciplinary action.
**ADMINISTRATIVE FINES AND RESTITUTION** 37

In addition to, or in lieu of, suspension or revocation, the Department may levy administrative penalties—the amount of which depends upon the infraction. For example, if the Department finds grounds for suspension of any license or appointment, the Department may impose an administrative penalty of as much as $500. However, if the Department finds willful misconduct led to the disciplinary action, the fine could be as much as $3,500. An amount equal to any commissions received or accruing in connection with the related transaction may augment any administrative penalties. With respect to insurance agencies, the administrative penalty may be up to $10,000 per violation. The same augmentation rules apply as well. Restitution to any person who has been deprived of money by the licensee’s misappropriation of moneys rightfully belonging to others may also be levied.

If administrative penalties are imposed and are not paid in full within 30 days, the offender’s status (suspension, revocation, etc.) will stand, even after the expiration period.

**DUTIES OF LICENSED VS UNLICENSED PERSONNEL**

A full-time clerical worker employed within an insurance agency is not required to be licensed as an agent or customer representative, even if they occasionally take applications, provide quotes or receive premiums—unless he or she receives commissions based on insurance sales. Unlicensed employees are prohibited from initiating contact with individuals for the purpose of soliciting insurance. Any employee who does so must be licensed and appointed. Only a licensed and appointed employee may bind insurance coverage. 38

Giving a quote refers to the basic tasks of obtaining certain basic underwriting answers from the inquirer, and then consulting written underwriting materials that state the rate.

Giving a quote does not involve:

- Application of judgment;
- Processing or binding;

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37 626.681, 626.692
38 626.0428
• Interpreting policies or procedures;
• Rendering advice and counsel; or
• Signing an application.\(^{39}\)

Unlicensed personnel may, at any time, perform the following functions:

• Serve in the capacity of switchboard operator, receptionist or secretary, taking incoming calls and messages and routing calls and visitors to licensed staff;
• Explaining claims procedures or claims status as long as the unlicensed employee reads strictly from agency records and files and does not apply judgment or interpretation;
• Have phone conversations with clients dealing strictly with administrative subjects; and
• Setting appointments for or passing on information to clients at the licensee’s request.\(^{40}\)

A licensed agent may only share a commission with another agent who is also licensed and appointed to write that specific line of business. Deferred commissions remain payable to an individual who is no longer licensed but who was previously licensed when the commission was earned.\(^{41}\)

It is unlawful for unlicensed insurance agency personnel to receive any type of pay that is formally tied to the production of insurance or insurance applications—doing so would constitute illegal sharing of commissions. However, if the agency had a good year and wanted to pay bonuses to their unlicensed employees, such as a Christmas bonus, there is no prohibition.\(^{42}\)

No individual unless licensed as a general lines agent may:

• Solicit insurance or procure applications for insurance;
• Accept monies for the purpose of procuring an insurance policy;
• Represent himself or herself out to be a licensed agent;

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\(^{39}\) 69B-222.020  
\(^{40}\) 69B-222.040  
\(^{41}\) 626.794, 626.838  
\(^{42}\) 69B-222.030
• Engage in the business of analyzing insurance policies or counseling or advising or giving opinions relative to insurance contracts; or

• Make or cause to be made any contract of insurance for any insurer.43

No individual may solicit or sell variable insurance products unless the individual has successfully completed the required license examination relating to variable contracts.

**CONTINUING EDUCATION**44

Continuing education is fundamentally imperative in the insurance industry. New agents may take basic level classes within the first six years of being licensed. After six years, agents must take intermediate or advanced level courses.

Courses may not be taken for credit more than once within a three-year period. Twenty-four (24) continuing education hours may be carried over to the next renewal period. The number of continuing education hours required depends upon the number of years the license is held and the license type. The compliance period is determined by the date of licensure and the licensee’s birth month. Continuing education hours are due the last day of the licensee’s birth month, after having held the license for 24 months.

**Example:**

Bill’s birth month is November and he was licensed on July 11, 2015. His compliance start date would be November 30, 2015 and his next continuing education due date would be November 30, 2017.

Many factors can affect a licensee’s continuing education requirements, such as the types of licensure held, the numbers of years licensed, and any carry over continuing education hours. Therefore, the Department encourages licensees to periodically check their *MyProfile* account to determine their individual continuing education compliance requirements and status. The *MyProfile* account also offers a wider selection of approved continuing education courses as the public search limits the results to the first 100 course offerings.

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43 626.7315
44 626.2815
Agents who do not complete the required continuing education hours by the end of their compliance period will be assessed a $250 fine and will have 60 days to become compliant.

**Duplicate Courses**

Continuing education providers offer assistance to make sure licensees are not taking a duplicate course; however, the licensee is ultimately responsible for choosing the appropriate course to remain compliant with the state’s continuing education requirements. Reasons why a licensee may not be aware that a course is a duplicate include:

- The title changed for an approved course;
- Course changed ownership to a new provider; and/or
- Course was subcontracted to a new provider.

**Reporting and Continuing Education Recordkeeping Requirements**

Effective October 1, 2012, course providers have 21 days to report completion of continuing education courses to the Department (the previous requirement was 30 days). Licensees should not submit certificates of completion to the Department unless specifically requested to do so.

Both the licensee and the course provider are required to maintain continuing education records. Providers must maintain attendance records for a period of five years and the records must be available in the event of an audit or a discrepancy in continuing education records. Licensees are responsible for maintaining a copy of their certificates of completion if ever requested by the Department for verification purposes.

**Continuing Education Exemption**

Licensees who are unable to comply with their continuing education requirements due to active duty in the military may submit a written request for a waiver to the Department.

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45 626.2815(2)
46 626.2815(2)
**FUNDS ACCOUNTABILITY**

An agent is the lawful representative of the principal (insurance company) as dictated by the law of agency. Any premium payments or other funds that are paid to the agent are the same as if they were paid to the insurance company. The agent has a legal as well as a fiduciary responsibility to turn the funds over to the insurance company immediately and not to use them for the agent’s own purposes. If funds are diverted or misappropriated, the guilty party will be subject to penalties from a misdemeanor to a first-degree felony, depending upon the amount of funds diverted or misappropriated.

- If the funds diverted or misappropriated are $300 or less, the offense is considered a misdemeanor of the first degree.
- If the funds diverted or misappropriated are more than $300 but less than $20,000, the offense is considered a third-degree felony.
- If the funds diverted or misappropriated are more than $20,000 but less than $100,000, the offense is considered a second-degree felony.
- If the funds diverted or misappropriated are more than $100,000, the offense is considered a first-degree felony.

In Chapter 4 of this course, you will be presented with case scenarios in which some agents diverted funds for their own personal use and the enforcement penalties they incurred.

**ADVERTISING CODE**

The NAIC developed an Advertising Code, which specifies certain words and phrases that are considered misleading and that are not to be used in advertising of any kind with regard to insurance business. To help ensure the insurance industry maintains a high level of public trust, the Code sets forth specific guidelines and model legislation.

Most advertising and sales literature used in an insurance agency is prepared by the agency and approved by the agency’s legal consultants. Florida law requires all advertising materials used to clearly state the intention of the advertisement as relating to insurance products—and agents must clearly
identify themselves to prospects as acting as insurance agents with regard to
insurance products. Use of any advertisement that would mislead the buying
public into mistakenly believing that the federal government backs or guarantees
an insurance product being offered in any way is prohibited.49

**Advertising gifts permitted** — For the purpose of advertising, agents and
insurers are permitted to give an article of merchandise having a value of no
more than $25.50.

No advertisement can be used that misleads the insurance-buying public in any
manner—deceptive words, phrases and illustrations are prohibited. No
advertisement can contain or use words or phrases such as “all,” “full,”
“complete,” “comprehensive,” “unlimited,” “up to,” “as high as,” “this policy will
help pay your hospital and surgical bills,” “this policy will help fill some of the
gaps that your present insurance leaves out,” and/or “this policy will help to
replace your income” (when used to express loss of time benefits), or similar
words and phrases in a manner that exaggerates any benefits beyond the terms
of the policy.

An advertisement for a policy providing benefits for specified illnesses only, such
as cancer, or for a limited benefit, such as nursing home coverage only, must
clearly and conspicuously in prominent type state the limited nature of the policy.
The statement must be worded in language identical or substantially similar to
the following:51

- **THIS IS A LIMITED POLICY**
- **THIS IS A CANCER ONLY POLICY**
- **THIS IS A NURSING HOME COVERAGE ONLY POLICY.**

All health insurance agents and sales representatives of an HMO are bound by
the following advertising rules:

“...all advertising must be truthful and not misleading in fact or implication.
Words or phrases shall be clear and understandable without reliance upon technical
terminology.”52

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49 626.9541  
50 626.9541(1)(m)  
51 69B-150.006  
52 69O-191.060
As long as an HMO holds a Certificate of Authority, the HMO is responsible for the acts of its agents and representatives.\textsuperscript{53}

**RECORDKEEPING**

Recordkeeping is an essential activity in the insurance business and many aspects of recordkeeping are regulated. Insurers must make records available to the Department as well as policyholders upon request, so it is a good idea to produce and securely retain backup copies just in case—especially in hurricane-prone Florida. Any records that pertain to premium payments must be kept for **at least three years** after payment. Please make note of the fact that the three-year requirement does not apply to insurance binders when no policy is ultimately issued and when no premium is collected.\textsuperscript{54}

Records of policy transactions, including daily reports, applications, change endorsements, or any documents signed or initialed by the insured must be maintained. Insurers may maintain records on behalf of the agent by any process that accurately reproduces the actual documentation, such as by photographic means, microprocess, magnetic, mechanical or electronic media.\textsuperscript{55}

**SENIOR CONSUMERS**\textsuperscript{56}

In the case of insurance transactions involving senior consumers, any information used in regard to recommendations that were the basis of the transaction must be kept for **five years** after completion of the transaction.

**DEPARTMENT COMMUNICATION**

Everyday, more and more people rely on their computers for more and more tasks—so must businesses that want to communicate with those people. Communication via the Internet is now the accepted and preferred method of communication.

The Department of Financial Services has improved their lines of communication with both agents and the public in much the same manner, by increasing their

\begin{footnotes}
\item[53] 69B-191.057
\item[54] 626.561
\item[55] 627.4554(6)(b)
\item[56] 627.4554(6)(a)
\end{footnotes}
reliance on this technology. The MyProfile portal DFS created facilitates easy and accurate communication with agents and agencies.

**MyProfile Account**

MyProfile is a full service online portal for the Bureau of Licensing through which agents and agencies can update their license profile and search for pertinent information regarding their license(s). A MyProfile account allows licensees to:

- View license(s), registration(s), appointment(s), continuing education requirements and deficiencies on any pending application;
- Update and verify address and name changes, including email addresses;
- Apply for an agent examination or license;
- Apply for an agency license or update agency information;
- Apply for a branch license;
- Print a duplicate license;
- Update the name of an agent-in-charge; and, among other things,
- Apply for a Letter of Certification and a Letter of Clearance.

Once a MyProfile account is created, the user will have to enter their personally created User Name and Password for re-entry. From there, navigation is simple.

**Insurance Insights**

INSURANCE Insights is the Division of Insurance Agent and Agency Services online newsletter. Licensees with valid email addresses on file with the Department are emailed the latest issues as they are published. INSURANCE Insights contains valuable information for agents and agencies to stay up to date on compliance matters and on the latest market trends.

For instance, the Department’s CFO laid out legislative initiatives for 2014 in an effort to make Florida more consumer- and business-friendly through:

- Ensuring Consumer Rights and Protections,
- Enacting Regulatory Reforms, and
- Enhancing the Fight Against Fraud.
The details of these initiatives can be found through INSURANCE Insights. Within each issue of the newsletter are the following sections.

- **News You Can Use** — Updating you on what’s going on.
- **In the Know** — Keeping you informed is what it’s all about.
- **Education Central** — Things to know about your continuing education.
- **Compliance Corner** — Assistance in keeping your insurance business in compliance.
- **Case Notes** — Reported instances involving violations of the Florida Insurance Code and the administrative action taken.
- **Enforcement Actions** — Disciplinary actions and settlement processes.

Present and past issues of INSURANCE Insights can be obtained by accessing the Division’s website at [www.myfloridacfo.com/division/agents/Newsletter/](http://www.myfloridacfo.com/division/agents/Newsletter/).

**TRANSPARENCY FLORIDA — AN OPEN DOOR TO FLORIDA’S FINANCES**

Another DFS enterprise is the creation of Transparency Florida, which allows the public to view state budgets, payments and contracts through the Division’s website at [www.myfloridacfo.com/Transparency/](http://www.myfloridacfo.com/Transparency/).

Through this portal, Floridians can view:

- State Government Information,
- State Financials and Employee Data,
- State Economic Incentives Programs,
- State Payments and Contract Audits,
- Where State Dollars Go: *Your Money Matters*, and
- A Transparency Glossary of Terms.

**FINANCES AND ECONOMY & FRAUD AND CONSUMER PROTECTION**

Among the CFO’s initiatives is the webpage “Finances and Economy,” which provides links to information such as the following.

- **The Office of Fiscal Integrity** — A criminal justice agency whose mission is to detect and investigate the misappropriation or misuse of state assets.
• **Financial Education** — *Your Money Matters* provides educational tools for Florida citizens in such subjects as the Affordable Care Act and how to start your own business.

• **On Guard for Seniors** — Provides seniors the information they need about insurance and financial transactions to make sound financial decisions, including annuities, reverse mortgages, long-term care, identity theft and consumer alerts.

  On Guard for Seniors has issued a Consumer Alert regarding a new scam involving unclaimed property in Florida. A company representative calls the consumer identifying himself or herself as “The Florida Department of Financial Restitution.” They tell the consumer that they need to collect a $600 upfront fee to recover unclaimed property on the consumer’s behalf. There is no such legal entity and consumers are urged to contact the Department if they are contacted by anyone representing himself or herself in this manner.

• **Holocaust Fee Waiver** — Holocaust survivors and their families are being assessed an international wire transfer fee that is taxed at the rate of 10% per payment. The website provides access to fee waiver forms that are now recognized by several financial institutions that have partnered with DFS to waive the wire transfer fee on reparation payments.

• **Deferred Compensation** — Provides information about Florida’s Government Employees Deferred Compensation Plan. Enrollment procedures, investment providers, investment performance, and planning tools are provided through this website to assist Florida government employees in their decisions about retirement planning. Users must create a secure login for access to the full realm of educational materials available.

• **Unclaimed Property** — The Florida Treasure Hunt website allows citizens to search for unclaimed property from dormant or abandoned accounts and safe deposit boxes.

  As a result of a Florida market conduct investigation, it was discovered that life insurance companies were using the Social Security Administration’s Death Master File to stop paying a deceased person’s annuity, but not using it to search for beneficiaries of a life insurance policy. Florida’s Office of Insurance Regulation became the first insurance regulator in the nation to enter into a regulatory settlement agreement.
requiring corrective actions pertaining to claims settlement practices and the reporting and remitting of unclaimed property.

There are two ways the identified property and/or funds are being returned to Florida consumers: (1) Directly from the life insurance company, and (2) through the Bureau of Unclaimed Property. As a result of the life claim settlement agreements, over $1 billion has been returned to beneficiaries directly by the companies and over $1.3 billion has been delivered to the states.57

• **Florida’s Bottom Line** — Provides an in-depth look at Florida’s financial health.

The “Fraud and Consumer Protection” link provides additional information such as the following.

• **The Division of Consumer Services** — Helps consumers make informed insurance and financial decisions.

• **Medicaid and Public Assistance Fraud Strike Force** — Works toward the prevention, detection and prosecution of Medicaid and public assistance fraud.

• **The Division of Insurance Fraud** — Responsible for investigating all types of insurance fraud, including claims fraud, premium fraud, workers’ compensation fraud, unauthorized insurance and entity fraud.

• **Money Service Business Workers’ Comp Fraud Work Group** — This work group conducts in-depth reviews of the practices involved in the check cashing services industry that aid in workers’ compensation premium fraud.

• **Report Fraud** — A link for consumers to report suspected fraud or if they are a victim of fraud.

• **The Division of Public Assistance Fraud** — Works to prevent, detect and prosecute public assistance fraud.

57 [www.flor.com/Sections/LandH/life_claims_settlement_practices](http://www.flor.com/Sections/LandH/life_claims_settlement_practices)
• **The Division of Workers’ Compensation** — Educating the public about workers’ compensation rights and responsibilities and accident prevention.

• **The Bureau of Fire and Arson Investigations** — Conducts fire, arson, insurance fraud, motor vehicle theft, terrorism and explosives investigations.

• **The Office of Fiscal Integrity** — Investigates complex contract and grant fraud and schemes that involve the theft of state funds.

Communication is the key component in the Department’s website—communication for licensees and consumers alike. All of these services provided, and more, are available on the Department’s website at [www.myfloridacfo.com/sitePages/Initiatives/](http://www.myfloridacfo.com/sitePages/Initiatives/).

On the main page of Agent and Agency Services, users can find a window of “Industry Alerts.” This window provides a listing of amendments, updates, notices, enforcement actions, notices of proposed Rule developments, etc.—recent information that can keep your knowledge of the industry updated.

**GUARANTY ASSOCIATIONS**

Guaranty associations are established to support insurers and protect consumers by guaranteeing payments in regard to life and health insurance in the case of insurer insolvency. Guaranty associations are funded through insurer assessments.

**FLORIDA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

The Florida Life and Health Insurance Guaranty Association (FLAHIGA) was created in 1979 and is composed of all insurers licensed to sell direct life insurance, accident and health insurance and certain annuities in the state of Florida. Should an insurer become insolvent, FLAHIGA takes over the liquidated insurer’s existing accounts so that policyholders will retain their coverage and benefits eligibility. FLAHIGA obtains policy records and history from the liquidator, collects premiums, administers policies and pays all valid claims. FLAHIGA has paid out hundreds of millions of dollars for claims and underlying expenses. FLAHIGA is not an insurance company, however, so the association

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58 631.711-631.737
will typically transfer acquired policies to a new, stable insurer with approval of the state.

There are also limits to the maximum amount of coverage FLAHIGA will pay. If an insurance company fails, the maximum amount of protection provided for any one person is:

- **Life Insurance Death Benefit** — $300,000 per insured life
- **Life Insurance Cash Surrender** — $100,000 per insured life
- **Health Insurance Claims** — $300,000 per insured life
- **Annuity Cash Surrender** — $250,000 per deferred annuity contract per contract owner
- **Annuity Benefit** — $300,000 per contract owner

The use of advertisement of FLAHIGA is prohibited as an inducement for sales, solicitation or purchase of any form of insurance that is covered by FLAHIGA. However, written information prepared by the association that summarizes the claim, cash value, and annuity cash value limits of the association may be provided to a policyholder or applicant upon his or her request.

In Florida, insureds bear no liability on the part of any licensed and appointed insurance agent for the insolvency of any risk bearing entity that has been duly authorized or approved to do business in the state. However, if the agent was a controlling producer of the entity within two years preceding the insolvency, the agent is subject to penalty.

“Risk bearing entity,” in this regard, means a reciprocal insurer, a commercial self-insurance fund, a group self-insurance fund, a local government self-insurance fund, a self-insured public utility or an independent educational institution self-insurance fund.59

**FLORIDA HEALTH MAINTENANCE ORGANIZATION CONSUMER ASSISTANCE PLAN**60

The Florida Health Maintenance Organization Consumer Assistance Plan (HMOCAP) is a nonprofit entity that was created for much the same reason as

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59 626.9531
60 631.811-631.828
FLAHIGA. HMOCAP provides protection for commercial HMO members—those who have group HMO coverage, usually provided through their employer, or for persons who purchase individual coverage directly through an HMO. HMOCAP’s purpose is to protect persons enrolled for coverage with HMOs due to insolvency—again, subject to certain limits. HMOCAP benefits will cease:

- After six months of coverage (allowing the member to attain replacement coverage);
- Upon failure to pay plan premiums; or
- Once the plan has provided $300,000 in covered benefits for a single person.

Generally, HMOCAP works with other HMOs in the service area to provide replacement coverage as soon as possible for its covered members.

Benefits and premiums remain the same for the six-month period. If a covered individual was under treatment for an injury or illness that was diagnosed while the person was still covered by the insolvent HMO, HMOCAP will remain responsible for that individual’s medical care for that treatment until the plan has reached its $300,000 limit.
CHAPTER 1 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence best?
(Answers are in the back of the text.)

1. Any person or entity knowingly conducting insurance acts without proper licensure can be subject to a:
   a) first-degree felony conviction.
   b) second-degree felony conviction.
   c) third-degree felony conviction.
   d) misdemeanor.

2. Licensees are not required to file another application or take another exam once a license has been issued unless the licensee fails to procure appointment within _____ of licensure.
   a) 30 days
   b) 12 months
   c) 18 months
   d) 48 months

3. An agent who is operating independently out of his or her residence from which consumers can conduct insurance transactions and inquiries is required to:
   a) obtain an agency license.
   b) have a separate entrance to the office.
   c) file a dba.
   d) notify the IRS.

4. The same agent can act as full time agent-in-charge of multiple locations:
   a) whether the agent is physically present or not.
   b) as long as insurance activities requiring licensure as an insurance agent do not occur at any location for which the agent is not physically present.
   c) if there is only one licensed agent for each location.
   d) unless the total combined business generates more than $10,000 in premium sales annually.
5. Agents who do not complete their required continuing education hours by the end of their compliance period will be assessed a ______ fine.

   a) $50
   b) $100
   c) $250
   d) $2,500
INSURANCE LAW AND UPDATES

The primary purpose of insurance regulation is to protect the welfare of the insurance public. The history of regulation has been aimed at protecting consumers, ensuring fair trade practices, and guarding against insurer insolvency.

The Department of Financial Services instructs licensees that it is their responsibility to be familiar with all laws and administrative regulations applicable to the respective license(s) held. To begin with, we will take a close look at Senate Bill 166 and its impact on Florida annuity suitability requirements in the purchase, exchange and replacement of annuities. After which we will move on to study many of the latest changes licensees may or may not, but should, be aware of. In this chapter, we will take a look at the latest federal laws that affect Florida licensed insurance professionals, including the passage of Senate Bill 166 regarding annuities, the Affordable Care Act, and the Dodd-Frank Act.

FEDERAL LAWS AFFECTING FLORIDA INSURANCE PROFESSIONALS

Previously, suitability analysis requirements were mainly focused on the senior population, those consumers age 65 or older. Effective October 1, 2013 with the passage of Senate Bill 166, the same suitability requirements apply to all consumers regardless of age. The amendments combine the NAIC 2010 Suitability in Annuity Transactions Model Regulation and the 2010 Safeguard Our Seniors Act.

Insurers are now required to provide training for producers on the features of the products the agency sells. Verification of training must be provided before producers present their products to consumers. We will take a closer look at this requirement in “Required Ongoing Training” in this chapter.

SB 166 – “Annuites; Providing that recommendations relating to annuities made by an insurer or its agents apply to all consumers not just to senior consumers; increasing the period of time that an
unconditional refund must remain available with respect to certain annuity contracts; making such unconditional refunds available to all prospective annuity contract buyers without regard to the buyer’s age, etc.”

Following is a list of consumer protections primarily contained in the Bill.61

- **Suitability of Annuities** — The Bill requires an insurer or insurance agent recommending the purchase or exchange of an annuity that results in an insurance transaction to have reasonable grounds for believing the recommendation is suitable for the consumer, based on the consumer’s suitability information. The Bill imposes additional duties on insurers and insurance agents when a transaction involves the exchange or replacement of an annuity.

- **Documentation of Sales Transactions** — The Bill requires agents and agent representatives to record recommendations made to a consumer.

- **Prohibitions on Agents** — The Bill prohibits agents from dissuading or attempting to dissuade a consumer from truthfully responding to the insurer’s request for suitability information, filing a complaint or cooperating with the investigation of a complaint.

- **Unconditional Refund Period** — The Bill expands to 21 days (from the previous 14 days) the unconditional refund period for all purchasers of fixed and variable annuities.

- **Limit on Surrender Charges** — The Bill retains the prohibition against surrender charges or deferred sales charges in annuity contracts issued to a senior consumer from exceeding 10% of the amount withdrawn. The charge must be reduced so that no surrender or deferred sales charge exists after the end of the tenth policy year or ten years after the premium is paid, whichever is later.

- **Penalties** — Authorizes the imposition of corrective action, appropriate penalties and sanctions on insurers, agents, managing general agencies or insurance agencies that violate the requirements of Section 627.4554. An insurance agent must pay restitution to a consumer whose money the agent misappropriates, converts or unlawfully withholds.

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61 CS/CS/SB 166 - Annuities
The Bill amends Section 627.4554, F.S., to incorporate into Florida law the most current version of the NAIC model regulation on annuity transactions while maintaining most of the provisions adopted by Florida in 2008 and 2010. The following changes became effective on October 1, 2013.  

**Suitability Information**

Florida requires consumer suitability forms to be presented to the insurer within 10 days after execution of the form and provided to the consumer no later than on the date of contract delivery. If the consumer refuses to provide suitability information, the agent must obtain the consumer’s signed statement documenting his or her refusal to provide the requested information.

In performing a suitability analysis, the following key points need to be analyzed:

- The age and sex of the party(ies) to the annuity as well as the number of dependents and their respective ages;
- Annual income;
- Financial situation and needs, including financial resources used for the funding of the annuity;
- Financial experience and investment objectives;
- Intended use of the annuity and time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquid net worth and liquidity needs;
- Risk tolerance; and
- Tax status.

**Duties of Insurers and Agents**

When recommending the purchase or exchange of an annuity to a consumer which results in an insurance transaction, the agent must have reasonable grounds for believing that the recommendation is suitable for the consumer,

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62 SB 166, 2013
63 627.4554(5)(b)
64 627.4554(5)(a)
based on the consumer’s suitability information, and that there is a reasonable basis to believe all of the following.

- The consumer has been reasonably informed of various features and potentials of the annuity, such as surrender periods and surrender charges; tax penalties; mortality and expense fees; investment advisory fees; policy rider charges and features; limitations on interest returns; insurance and investment components; and market risk.

- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization, or the death or living benefit.

- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, including any riders or product enhancements are suitable; and, in the case of an exchange or replacement, the transaction as a whole is suitable based on the acquired suitability information.

Agents should pay particular attention as to whether the consumer has exchanged or replaced another annuity within the last 36 months.

**REQUIRED ONGOING TRAINING**

Insurers are required to establish a suitability supervision system, which monitors producers’ sales. Agents must be provided product-specific training and materials that explain all material features of their annuity products.

The supervision system must be designed to:

- Maintain procedures for the review of each recommendation before annuity issuance, which are designed to ensure that there is a reasonable basis for determining that a recommendation is suitable; and

- Maintain procedures to detect recommendations that are unsuitable, such as through the confirmation of consumer suitability information, systematic customer surveys, consumer interviews, confirmation letters and internal monitoring programs.

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65 627.4554(5)(g)
The law requires every insurer to report annually to its senior management on the effectiveness of its suitability supervision system, any exceptions discovered and any corrective action taken.

An agent may not dissuade, or attempt to dissuade a consumer from truthfully responding to an insurer’s request for confirmation of suitability information, filing a complaint or cooperating with the investigation of a complaint.

**RECORDKEEPING**

At the time of sale, the producer must make a record of any recommendation made to the consumer, which contains the information collected from the consumer and any other information used that was the basis for the transaction. Records must be kept and made available for five (5) years after the transaction is completed or for as long as the annuity remains in force, whichever is longer. As always, an insurer may maintain the documentation on behalf of its agent.

**PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)**

PPACA (the “Act”), commonly called the Affordable Care Act (ACA) or “Obamacare,” is the most recent prime example of federal regulation regarding healthcare reform. The goal of the PPACA is to increase the quality and affordability of health insurance, lower the uninsured rate and reduce the costs of healthcare for both individuals and the government. The Act requires insurers to cover all applicants within minimum standards and offer the same rates regardless of preexisting conditions or gender.

The comprehensive health care reform law was enacted in March 2010. The Act was signed into law on March 23, 2010 and amended by the Health Care and Education Reconciliation Act on March 30, 2010.

Some of the reforms are on schedule to be phased in through 2020; however, most of the reforms had an effective date of January 1, 2014, including:

- Guaranteed issue;
- Minimum standards for health insurance policies;
- Mandatory participation (or pay a penalty);

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66 627.4554(6)
• Federal subsidies on a sliding scale for low-income individuals;
• Federal subsidies for small businesses;
• Medicaid eligibility expansion—includes individuals within 138% of the federal poverty level (voluntary participation by individual states);
• Medicare payment restructure; and
• The creation of state-based insurance exchanges where individuals and small businesses can purchase health insurance plans.

On March 31, 2014, open enrollment for the first year of the healthcare exchange marketplace ended, exceeding its goal of enrollees.

**NAVIGATOR**

Navigator is a new category of insurance professional created to assist health insurance consumers to find insurance coverage through insurance exchanges. The position of navigator was created to fulfill mandates imposed by the PPACA. Beginning August 1, 2013, individuals are prohibited from advertising or acting as a navigator unless registered with the Department. The purpose of registration is to identify qualified individuals to assist the insurance-buying public in selecting a qualified health plan through an exchange. Navigators are responsible for providing fair, accurate, and impartial information regarding qualified health plans and the availability of premium tax credits and cost-sharing reductions. The Department will not approve the registration of an individual as a navigator who is found to be untrustworthy or incompetent. Navigators must meet the following requirements to be approved and registered with the Department:

• Must be a natural person at least 18 years of age;
• Must be a United States citizen or legal alien who possesses work authorization from the United States Bureau of Citizenship and Immigration Services; and
• Must have successfully completed all training for a navigator as required by the federal government or the exchange.

Each application must include a nonrefundable application filing fee of $50. Upon approval of an application for registration, the Department will add the registrant’s

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67 626.995-626.9958
name to its publicly available list of registered navigators in order for operators of an exchange and other interested parties to validate a navigator’s registration.

Navigators are required to notify the Department within thirty (30) days after a change of name, residence address, principal business street address, mailing address, contact telephone number (including a business telephone number), or email address. Failure to do so subjects the registrant to a fine of up to $250 for the first offense, and a fine of at least $500 or suspension or revocation for subsequent offenses. An individual whose registration has been revoked may not apply for registration as a navigator until two years after the effective date of the revocation.

Navigators are prohibited from:

- Soliciting, negotiating, or selling health insurance;
- Recommending the purchase of a particular health plan or represent that one health plan is preferable over any other;
- Recommending or assisting with the cancellation of insurance coverage purchased outside the exchange; and
- Receiving compensation or anything of value from an insurer, health plan, business, or consumer in connection with performing activities as a navigator, other than from the exchange or from an entity or individual who has received a navigator grant under the PPACA.

Individuals who have committed a felony of the first degree, a capital felony, a felony involving money laundering, fraud, or embezzlement, or any felony directly related to the financial services business are permanently barred from applying as a navigator.

**MEDICARE**

In the beginning, there was much speculation on what effects the Affordable Care Act might have on those seniors who are covered under Medicare—even speculation that the PPACA would replace Medicare entirely. Most seniors, however, have been able to enjoy the benefits, rights and protections of the new health care law with little or no change to their insurance costs. Since the Affordable Care Act was passed in 2010, Medicare Advantage premiums have fallen by 10% and enrollment has increased by nearly 33% to an all-time high of approximately fifteen million (15,000,000) beneficiaries. The Centers for
Medicare and Medicaid Services reports that nearly 30% of Medicare beneficiaries are enrolled in a Medicare Advantage plan.\(^{68}\)

The Affordable Care Act’s Essential Health Benefits made drug coverage mandatory for non-grandfathered health insurance. Beginning in 2014, individual and small group plans are required to provide coverage for at least the following categories:

- **Ambulatory Patient Services** — Includes outpatient services, such as doctor visits;
- **Emergency Services** — Includes care received in an Emergency Room;
- **Hospitalization** — Includes medically-necessary surgeries and other inpatient procedures;
- **Maternity** — Includes newborn care;
- **Mental Health Services**;
- **Substance Use Disorder Services** — Includes behavioral health treatment;
- **Prescription Drug Coverage**;
- **Rehabilitative and Habilitative Services and Devices** — Includes services such as relearning to walk after a stroke; and habilitation involves learning, keeping, or improving skills such as speaking without an impediment;
- **Laboratory Tests and Services**;
- **Preventive and Wellness Services** — Includes the management of chronic diseases; and
- **Pediatric Services** — Includes both oral care and vision care.

There are two ways to get Medicare prescription drug coverage—by adding a Medicare Prescription Drug Plan (Part D, also known as “Medicare Rx”), or by getting a Medicare Advantage Plan (Part C) such as an HMO or PPO that offers Medicare prescription drug coverage. Each Medicare Prescription Drug Plan has its own formulary of covered drugs, and many place drugs into different “tiers.” Drugs in each tier have a different cost—a drug in a lower tier will generally cost less than a higher tier drug. In some cases, however, if the beneficiary’s drug is

\(^{68}\) CMS Press Release 2014-02-21
on a higher tier and the prescriber believes that the beneficiary needs that particular drug rather than a lower-tier drug, the prescriber or beneficiary can ask the plan for an exception to get a lower copayment.

**MEDICARE PART A (HOSPITAL INSURANCE) COSTS**

Medicare premiums and deductibles typically rise on an annual basis. Most people don’t pay a Part A premium because they paid Medicare taxes while working. If a beneficiary doesn’t get premium-free Part A and they paid Medicare taxes for less than 30 quarters, standard Part A premium is $413. If they paid Medicare taxes for 30-39 quarters, the standard Part A premium is $227 (2017).

**Hospital Inpatient Stay (2017)**
- $1,316 deductible for each benefit period
- Days 1-60: $0 coinsurance per day of each benefit period
- Days 61-90: $329 coinsurance per day of each benefit period
- Days 91 and beyond: $658 coinsurance per each “lifetime reserve day” after 90 for each benefit period (up to 60 days over your lifetime)
- Beyond lifetime reserve days: All costs

**Home Health Care**
- $0 for home health care services
- 20% of the Medicare-approved amount for durable medical equipment

**Hospice Care**
- $0 for hospice care
- A copayment of no more than $5 for each prescription drug and other similar products for pain relief and symptom control while the patient is at home may apply
- 5% of the Medicare-approved amount for inpatient respite care may apply

**Late Enrollment Penalty**
If an individual doesn’t buy Part A when first eligible, the monthly premium may go up 10%—you’ll have to pay a higher premium for twice the number of years you could have had Part A, but didn’t sign up.
**Medicare Part B (Medical Insurance) Costs**

The standard Part B premium amount in 2017 is $134 (or higher depending on income). However, most people who get Social Security benefits will pay less than this amount. This is because the Part B premium increased more than the cost-of-living for 2017 Social Security benefits. If the Part B premium is paid through the monthly Social Benefit, the beneficiary will pay less ($109 on average). Individuals will pay the standard premium amount of:

- You enroll in Part B for the first time in 2017;
- You don’t get Social Security benefits;
- You’re directly billed for your Part B premiums;
- You have Medicare and Medicaid, and Medicaid pays your premiums (the state will pay the standard premium amount of $134);
- Your modified adjusted gross income from two years ago is above a certain amount. If so, you’ll pay the standard premium amount and an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to the premium. (See table below)

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**Illustration 1.1**

<table>
<thead>
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<th></th>
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<td>$85,000 or less</td>
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<td>$85,000 or less</td>
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<td>Above $214,000</td>
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<td>Above $129,000</td>
<td>$428.60</td>
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</table>

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**Part B Deductible and Coinsurance (2017)**

- $183 per year: After the deductible is met, the individual will typically pay 20% of the Medicare-approved amount for most doctor services (including
most doctor services while a hospital inpatient), outpatient therapy and
durable medical equipment;

- Clinical laboratory services: $0 for Medicare-approved services;
- Home health services: $0 for home health care services; 20% of the
  Medicare-approved amount for durable medical equipment.

**Outpatient Mental Health Services**

- $0 for yearly depression screening if a doctor or health care provider
  accepts assignment;
- 20% of the Medicare-approved amount for visits to a doctor or other health
  care provider to diagnose or treat the condition—the Part B deductible
  applies.
- If services are received in a hospital outpatient clinic or hospital outpatient
  department, an additional copayment or coinsurance amount may apply.

**Partial Hospitalization Mental Health Services**

You pay a percentage of the Medicare-approved amount for each service
received from a doctor or certain other qualified mental health professionals if the
health care professional accepts assignment. You also pay coinsurance for each
day of partial hospitalization services provided in a hospital outpatient setting or
community mental health center, and the Part B deductible applies.

**Outpatient Hospital Services**

- Generally, 20% of the Medicare-approved amount for the doctor or other
  health care provider’s services, and the Part B deductible applies.
- For all other services, a copayment for each service received in an
  outpatient hospital setting applies. Services received in a hospital
  outpatient setting usually cost more for the same care if received in a
  doctor’s office.
- For some screening and preventive services, coinsurance, copayments
  and the Part B deductible do not apply.

**Late Enrollment Penalty**

In most cases, if an individual doesn’t sign up for Part B when first eligible, they
will have to pay a late enrollment penalty, which they will have to pay for as long
as they have Part B. The monthly premium for Part B may go up 10% for each
full 12-month period that the individual could have had Part B but didn’t sign up
for it. Also, they may have to wait until the general enrollment period (from January 1 to March 31) to enroll in Part B. Coverage will begin July 1 of that year.

**MEDICARE PART C (MEDICARE ADVANTAGE) COSTS**

Part C monthly premium varies by plan. The amount paid for Part C deductibles, copayments and/or coinsurance varies by plan.

When buying a Medicare Advantage Plan (Medigap), the individual pays a premium to the carrying insurance company. Any policy purchased after 1992 is renewed automatically as long as premiums continue to be paid. (In some states, insurance companies may refuse to renew a Medigap policy bought before 1990. At the time these policies were sold, state law was not required to say the Medigap policies had to be renewed automatically each year.)

**Basic Benefits**

- **Inpatient Hospital Care Benefit** — Medicare Part A coinsurance and 365 days hospital care for life after the Original Medicare plan coverage ends
- **Medical Costs** — Medicare Part B coinsurance and copayment amounts according to services received
- **Blood** — The cost of the first three pints of blood used each year

Purchasing a Medigap policy is not necessary if the individual is already enrolled in a Medicare Advantage plan. In fact, it is illegal for anyone to knowingly sell such person a Medigap policy. It is also illegal for an insurance company to sell an individual a Medigap policy if that person has Medicaid, except in certain situations such as:

- If Medicaid pays the individual’s Medigap policy premium;
- If Medicaid pays the individual’s Medicare premiums, deductibles or coinsurance; or
- If Medicaid only pays all or part of the individual’s Medicare Part B premium.

In any other situation, it is illegal for an insurance company to sell a Medigap policy to an individual who has Medicaid.

**Part A Gaps**

- Part A deductible
• Part A coinsurance
• Skilled nursing facility coinsurance

**Part B Gaps**

• Part B deductible
• Part B coinsurance
• Part B excess charges

**Noncovered Services**

Medigap policies do not cover the following services:

• Long-term care,
• Vision or dental care,
• Hearing aids,
• Private duty nursing, or
• Unlimited prescription drugs.

**MEDIGAP PLANS A THROUGH N**

Medigap policies (including Medicare SELECT) can only be sold in ten standardized plans. The table below shows basic information about the different benefits Medigap policies cover.

• Yes = The plan covers 100% of this benefit
• No = The policy doesn’t cover that benefit
• % = The plan covers that percentage of this benefit

The illustration below gives a quick and easy look at all the Medigap plans and what benefits are in each plan.
## Medicare Supplement Insurance (Medigap) Plans

<table>
<thead>
<tr>
<th>Benefits</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>F*</th>
<th>G</th>
<th>K*</th>
<th>L*</th>
<th>M</th>
<th>N*</th>
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<td>Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Medicare Part B coinsurance or copayment</td>
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<td>100%</td>
<td>50%</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Blood (first 3 pints)</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>50%</td>
<td>75%</td>
<td>100%</td>
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<td>Part A hospice care coinsurance or copayment</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>100%</td>
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<td>100%</td>
<td>100%</td>
<td>50%</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Part B excess charges</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>50%</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Foreign travel exchange (up to plan limits)</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

**Illustration 4.1**

*Plan F is also offered as a high-deductible plan by some insurance companies in some states. If a participant chooses this option, they must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,200 in 2017 before the Medigap plan pays anything.

**For Plans K and L, after meeting the out-of-pocket annual limit and annual Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.

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69 [www.medicare.gov](http://www.medicare.gov), *How to Compare Medigap Policies, 2017*
Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don’t result in an inpatient admission.

Medicare Advantage plans usually offer extra benefits and/or lower costs, but only if the participant uses the doctors and hospitals that participate in the plan’s network. If they do not opt for prescription drug coverage when they are first eligible, they may have to pay a late enrollment penalty to get drug coverage later.

**Medicare Part D (Medicare Prescription Drug Plan) Costs**

Medicare Part D provides beneficiaries with prescription drug coverage. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created Medicare Part D as an optional outpatient prescription drug benefit for individuals who are entitled to or who are enrolled in benefits under Medicare Part A, Part B, or both.

Joining a Medicare prescription drug plan is voluntary, and participants pay an additional monthly premium for the coverage. Participants can wait to enroll in a Medicare Part D plan if they have other creditable prescription drug coverage but if they don’t have prescription coverage that is, on average, at least as good as Medicare prescription drug coverage, they will pay a penalty if they wait to join later—and those participants will pay this penalty for as long as they have Medicare prescription drug coverage.

Beneficiaries who become newly entitled to Medicare should enroll during their initial enrollment period. After the initial enrollment period, the annual coordinated election period to enroll or make provider changes is October 15th through December 7th each year. There are also special enrollment periods for some situations.

The Part D monthly premium varies by plan (higher-income consumers may pay more). The table below shows the estimated prescription drug plan monthly premium based on income from two years ago and last year. If income is above a certain limit, an income-related monthly adjustment in addition to the plan premium applies.

<table>
<thead>
<tr>
<th><strong>PART D — IF YOUR YEARLY INCOME IN 2015 WAS:</strong></th>
<th></th>
</tr>
</thead>
</table>

55
### Illustration 1.2

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
<td>$85,000 or less</td>
<td>Your plan premium</td>
</tr>
<tr>
<td>Above $85,000 up to $107,000</td>
<td>Above $170,000 up to $214,000</td>
<td>Not applicable</td>
<td>$13.30 + plan premium</td>
</tr>
<tr>
<td>Above $107,000 up to $160,000</td>
<td>Above $214,000 up to $320,000</td>
<td>Not applicable</td>
<td>$34.20 + plan premium</td>
</tr>
<tr>
<td>Above $160,000 up to $214,000</td>
<td>Above $320,000 up to $428,000</td>
<td>Above $85,000 up to $129,000</td>
<td>$55.20 + plan premium</td>
</tr>
<tr>
<td>Above $214,000</td>
<td>Above $428,000</td>
<td>Above $129,000</td>
<td>$76.20 + plan premium</td>
</tr>
</tbody>
</table>

Anyone who has Medicare Parts A, B, or C is eligible for Medicare prescription drug coverage, Part D. Participants can wait to enroll in a Medicare Part D plan if they have other creditable prescription drug coverage. But if they don’t have creditable prescription drug coverage, they will have to pay a penalty if they wait to join later—and those participants will pay this penalty for as long as they have Medicare prescription drug coverage.

Creditable prescription drug coverage is coverage that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

- Federal Employee Health Benefits (FEHB) Program
- Veterans’ Benefits
- TRICARE (military health benefits)
- Indian Health Services

### Dodd-Frank Wall Street Reform and Consumer Protection Act

The Dodd-Frank Act of 2010 brought comprehensive regulation to financial institutions in an attempt to prevent the recurrence of events that caused the financial crisis of 2007-2010. The federal law became effective on July 21, 2010.

The Act established regulatory authorities that are assigned the duties of monitoring the performance of companies deemed “too big to fail,” provide
funding to assist with the liquidation of financial companies that have been placed in receivership due to financial weakness, break up large banks that may pose a risk to the financial system because of their size, and liquidate or restructure firms deemed financially weak.

The stated aim of the Dodd-Frank Act is to:

“promote the financial stability of the United States by improving accountability and transparency in the financial system, to end “too big to fail,” to protect the American taxpayer by ending bailouts, to protect consumers from abusive financial services practices, and for other purposes.”

The “Financial Stability Act” (Title I) created the Financial Stability Oversight Council and the Office of Financial Research, whose main purposes are to:

- Identify the risks to the financial stability of the U.S. from both financial and non-financial organizations;
- Promote market discipline, by eliminating expectations that the federal government will shield them from losses in the event of failure; and
- Respond to emerging threats to the stability of the U.S. financial system.

Title V Subtitle A, also called the “Federal Insurance Office Act of 2010,” created the Federal Insurance Office (FIO) adding yet another regulatory authority within the insurance industry. The NAIC coordinates with the FIO to serve as an information resource for the federal government and to engage in international discussions in conjunction with U.S. insurance regulators.

The FIO is charged with monitoring all aspects of the insurance sector, including identifying activities that could potentially contribute to a systemic crisis to the broader financial system, the extent to which under-served communities have access to affordable insurance products, and the sector’s regulation.

**NEW FLORIDA-SPECIFIC UPDATES**

In addition to the updates in federal law that we have already discussed, there are several changes that directly affect the Florida insurance industry.

**FLORIDA HEALTH CHOICES**

The Florida Health Choices Corporation (FHC) was established in 2008 through the passage of SB 2534; but didn’t go live until March 2014. The Corporation was
established with the goal of providing Florida residents with access to affordable, quality health care and services without the hassle of dealing with the typical “one-size-fits-all” process of insurance buying. The original bill was passed in 2008 (SB 2534), but didn’t go live until March 2014.

**Eligible Participants**

Participation in the program is voluntary and is available to employers, individuals, vendors, and health insurance agents.

- **Small Employers** — 2 to 50 employees
- **Individuals** — Employees of enrolled employers; and individuals and their family members

Eligible vendors include:

- Health insurance policies;
- Health Maintenance Organizations;
- Discount Medical Plan Organizations;
- Limited Benefit Plans;
- Prepaid clinic services;
- Licensed health care providers – including hospitals, licensed health facilities, health care clinics, licensed health professionals, and pharmacies; and
- Provider organizations – including service networks, group practices, professional associations and other incorporated organizations of providers.

FHC initially offered “discount only” plans for some health services, such as dental services and prescription drugs. In early January 2015, FHC began offering health plans that were compliant with the Affordable Care Act and covered the ACA’s ten essential health benefits.
Ten Essential Health Benefits

The Affordable Care Act put into place a significant number of health insurance reforms in 2010, with several changes scheduled to roll out into 2014. As of January 1, 2014, no person can be declined coverage or charged extra for health insurance because of a preexisting health issue or condition. The Act’s ten essential health benefits are listed below.

1. **Ambulatory patient services (outpatient care)** — Care you receive without being admitted to a hospital, such as at a doctor’s office, clinic or same-day (outpatient) surgery center. Also included in this category are home health services and hospice care. (Note: Some plans may limit coverage to no more than 45 days.)

2. **Emergency Services (trips to the emergency room)** — Care you receive for conditions that could lead to serious disability or death if not immediately treated, such as accidents or sudden illness. Typically, this is a trip to the emergency room, and includes transport by ambulance. You cannot be penalized for going out-of-network or for not having prior authorization.

3. **Hospitalization (treatment in the hospital for inpatient care)** — Care you receive as a hospital patient, including care from doctors, nurses and other hospital staff, laboratory and other tests, medications you receive during your hospital stay, and room and board. Hospitalization coverage also includes surgeries, transplants and care received in a skilled nursing facility, such as a nursing home that specializes in the care of the elderly. (Note: Some plans may limit skilled nursing facility coverage to no more than 45 days.)

4. **Maternity and newborn care** — Care that women receive during pregnancy (prenatal care), throughout labor, delivery and post-delivery, and care for newborn babies.

5. **Mental health services and addiction treatment** — Inpatient and outpatient care provided to evaluate, diagnose and treat a mental health condition or substance abuse disorder. This includes behavioral health treatment, counseling, and psychotherapy. (Note: Some plans may limit coverage to 20 days each year. Limits must comply with state or federal parity laws.)

70 ObamacareFacts.com
6. **Prescription drugs** — Medications that are prescribed by a doctor to treat an illness or condition. Examples include prescription antibiotics to treat an infection or medication used to treat an ongoing condition, such as high cholesterol. At least one prescription drug must be covered for each category and classification of federally approved drugs; however, limitations do apply. Some prescription drugs can be excluded. “Over the counter” drugs are usually not covered even if a doctor writes you a prescription or them. Insurers may limit drugs they will cover, covering only generic versions of drugs where generics are available. Some medicines are excluded where a cheaper equally effective medicine is available, or the insurer may impose “Step” requirements (expensive drugs can only be prescribed if doctor has tried a cheaper alternative and found that it was not effective). Some expensive drugs will need special approval.

7. **Rehabilitative services and devices** — Rehabilitative services (help recovering skills, like speech therapy after a stroke) and habilitative services (help developing skills, like speech therapy for children) and devices to help you gain or recover mental and physical skills lost to injury, disability or a chronic condition (this also includes devices needed for “habilitative reasons). Plans have to provide 30 visits each year for either physical or occupational therapy, or visits to the chiropractor. Plans must also cover 30 visits for speech therapy as well as 30 visits for cardiac or pulmonary rehab.

8. **Laboratory services** — Testing provided to help a doctor diagnose an injury, illness or condition, or to monitor the effectiveness of a particular treatment. Some preventive screenings, such as breast cancer screenings and prostrate exams, are provided free of charge.

9. **Preventive services, wellness services, and chronic disease treatment** — This includes counseling, preventive care, such as physicals, immunizations and screenings, like cancer screenings, designed to prevent or detect certain medical conditions. Also, care for chronic conditions, such as asthma and diabetes.

10. **Pediatric services** — Care provided to infants and children, including well-child visits and recommended vaccines and immunizations. Dental and vision care must be offered to children younger than 19. This includes two routine dental exams, an eye exam and corrective lenses each year.
**Subsidies**

Since Florida Health Choices is Florida’s own version of online marketplace, subsidies are not available. Subsidies are available only through Healthcare.gov, the federally facilitated marketplace. FHC is aimed at people who earn too much money to qualify for premium subsidies. As of February 2016, 91 percent of Florida residents who had coverage through Healthcare.gov were receiving premium subsidies.

**Buyers’ Representatives**

Licensed health insurance agents are eligible to voluntarily participate as buyers’ representatives. A buyers’ representative acts on behalf of an individual purchasing health insurance and health services through the program by providing information about products and services available through the program and assisting the individual with both the decision and the procedure of selecting specific products. Serving as a buyers’ representative does not constitute a conflict of interest with continuing responsibilities as a health insurance agent if the relationship between each agent and any participating vendor is disclosed before advising an individual participant about the products and services available through the program. In order to participate, a health insurance agent must comply with the procedures established by FHC, including:

- Completion of training requirements;
- Execution of a participation agreement specifying the terms and conditions of participation;
- Disclosure of any appointments to solicit insurance or procure applications for vendors participating in the program; and
- Arrangements to receive payment from FHC for services rendered.

**Continuing Care Facilities — CS/HB 127**

The Gold Seal Program is an award program administered by the Agency for Health Care Administration (AHCA) and the Governor’s Panel on Excellence in Long-Term Care, for nursing homes that demonstrate excellence in long-term care over a sustained period of time. Recipients of the Gold Seal Aware may use the designation in their advertising and marketing. Of the 684 currently licensed nursing homes in Florida, 32 nursing homes hold the award. Among other requirements, a nursing home must provide evidence of financial soundness and
Out-of-Network Health Insurance Coverage; Down Syndrome — HB 221

House Bill 221 prohibits out-of-network providers from balance billing members of a PPO or EPO for emergency services or for nonemergency services when the nonemergency services are provided in a network hospital and the patient had no ability and opportunity to choose a network provider.

The bill also requires all PPOs to publish a list of their network providers on their websites, updated monthly; requires all PPOs to give subscribers notice regarding the potential for balance billing when using out-of-network providers; subjects certain facilities and licensed health care practitioners to disciplinary action for violations of the prohibition on balance billing; requires hospitals to publish information on their websites regarding their contracts with plans and providers of hospital-based services;

This bill was successful in adding Down syndrome to the list of required coverages, amending 627.6686, Section 1(b)(3). The new law states that a health insurance plan or health maintenance contract issued or renewed on or after April 1, 2009, must provide coverage to an eligible individual for “...treatment of autism spectrum disorder and Down syndrome through speech therapy, occupational therapy, physical therapy, and applied behavior analysis.” (Effective date July 1, 2016)

Opioids — SB 422

Senate Bill 422 created a new section to Florida statutes, 627.64194 with an effective date of January 1, 2017, which outlines the requirements of opioid coverage.

The Legislature found the abuse of opioids to be a serious problem that affects the health, social, and economic welfare of the state. An estimated 2.1 million people in the United States suffered from substance use disorders related to prescription opioid pain relievers in 2012. In fact, the number of unintentional overdose deaths from prescription pain relievers has more than quadrupled since 1999. Because of these findings, the Legislature determined that it is imperative for people suffering from pain to obtain the relief they need while minimizing the potential for negative consequences.
A health insurance policy that provides coverage for abuse-deterrent opioid analgesic drug products:

- May impose a prior authorization requirement for an abuse-deterrent opioid analgesic drug product only if the policy imposes the same prior authorization requirement for each opioid analgesic drug product without an abuse-deterrence labeling claim.

- May not require use of an opioid analgesic drug product without an abuse-deterrence labeling claim before authorizing the use of an abuse-deterrent opioid analgesic drug product.

“Abuse-deterrent opioid analgesic drug product” means a brand or generic opioid analgesic drug product approved by the U.S. Food and Drug Administration with an abuse-deterrence labeling claim that indicates the drug product is expected to deter abuse.

“Opioid analgesic drug product” means a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions in immediate-release, extended-release, or long-acting form regardless of whether or not combined with other drug substances to form a single drug product or dosage form.

**MEDICAID EXPANSION**

Florida has been fighting its own internal battle over Medicaid expansion over the last few years. At the heart of the matter is the state’s Low Income Pool (LIP) program. Florida is one of 19 states that has not yet expanded Medicaid and had the fifth-highest uninsured rate in the country in 2014. The LIP program received approximately $2.1 billion in federal dollars in 2015, but funding was scheduled to end on June 30, 2015. As the deadline approached, Governor Rick Scott sued CMS because the agency refused to renew Florida’s LIP funding, and Scott’s administration saw this as coercion to try to get them to expand Medicaid. In May 2015, CMS sent word that Florida could still qualify for $1 billion in LIP funding for the 2016 fiscal year, but that funding would drop to $600 million in 2017 with no provision for funding starting in June 2017. As a condition to provide continued LIP funding, the monies cannot be used for expenses that would have otherwise been covered if Florida had agreed to accept $50 billion for Medicaid expansion.
With a lawsuit being filed and later being dropped, the state is no further along in negotiations to settle the dispute.71

RECOMMENDATIONS TO SURRENDER — HB 1133

House Bill 1133 amended F.S. §627.4553, effective July 1, 2015, with regard to recommendations to surrender, without replacement, annuity or life insurance policies.

If an insurance agent recommends the surrender of an annuity or life insurance policy containing a cash value and does not recommend that the proceeds from the surrender be used to fund or purchase another annuity or life insurance policy, before execution of the surrender, the agent must provide written information relating to the surrender before the surrender is complete.

The information must include, but is not limited to:

- The estimated amount of any surrender charge;
- The loss of any minimum interest rate guarantees;
- The possibility of tax consequences;
- The amount of any forfeited death benefit; and
- A description of any other investment performance guarantees being forfeited as a result of the transaction.

The agent must keep a copy of the information provided to the client and the date that the information was provided to the owner.

“Surrender” in this context means the voluntary surrender at the owner’s request of the annuity or life insurance policy before its maturity date in exchange for the policy’s current cash value, which results in a surrender or termination of the policy or contract.

INSURANCE AGENT AND AGENCY AMENDMENTS — HB 633

HB 633, effective July 1, 2014, amended the statutes relating to the regulation of insurance agents and agencies. Following is a summary of the changes.

71 HealthInsurance.org, March 18, 2016
• Provides for service of documents used to initiate administrative proceedings by electronic mail if service cannot be obtained by other means, allows for service by hand delivery by a department investigator and service by publication.72

• Eliminates the insurance agency licensing requirement for agencies owned and operated by a single licensed agent if the branch agencies transact business under the same tax identification number and if the agent has designated an agent in charge for each location.73

• Allows third parties to sign agency applications; however, the insurance agency is responsible for ensuring that the information on the application is true and correct and is accountable for any misstatements or misrepresentations.74

• Repeals a provision allowing insurance agencies to obtain a registration in lieu of a license, converts all agency registrations to licenses, and eliminates the three-year expiration period for agency licenses.75
  
  o The license of an insurance agency may continue in force until canceled, suspended, or revoked, or until it is otherwise terminated or expires by operation of law.

• Provides for agency licenses to automatically expire if the agency does not designated a new agent in charge with the DFS within 90 days after the agent in charge on record has left the agency.76
  
  o The agency license will automatically expire on the 91st day from the date the designated agent in charge ended his or her affiliation with the agency.

• Creates a new type of insurance agent, an unaffiliated insurance agent, to allow an agent who is not appointed by an insurance company to maintain his/her license instead of allowing the license to expire after four years.77
  
  o “Unaffiliated insurance agent” means a licensed insurance agent, except a limited lines agent, who is self-appointed and who practices as an independent consultant in the business of analyzing

72 624.310  
73 626.112  
74 626.172  
75 626.382  
76 626.0428  
77 626.015
or abstracting insurance policies, providing insurance advice or counseling, or making specific recommendations or comparisons of insurance products for a fee established in advance by written contract signed by the parties. An unaffiliated insurance agent may not be affiliated with an insurer, insurer-appointed insurance agent, or insurance agency contracted with or employing insurer-appointed insurance agents.

- Requires the Department to immediately suspend the license or appointment of licensees charged with crimes that would preclude them from applying for licensure.\(^{78}\)
  - The suspension will continue if the licensee is found guilty of, or pleads guilty or nolo contendere to, the crime—regardless of whether a judgment or conviction is entered during a pending appeal.

- Exempts members of the U.S. Armed Forces, their spouses, and veterans who have retired within 24 months from the application filing fee for specified licenses.
  - Qualified individuals must provide a copy of a military document verifying the service member is currently in good standing or has been honorably discharged.

**Beneficiary Designations in the Case of Divorce\(^ {79}\)**

Effective July 1, 2012, a change in Florida law has impacted beneficiary designations in divorce situations. Often when a couple divorces, they can lose sight of the many beneficiary designations they have created over the years to protect each other while married. The 2012 law applies to:

- Life insurance policies;
- Qualified annuities or other similar tax deferred contracts;
- Employee benefit plans;
- IRAs and 401(k)s;
- Pay-on-death accounts; and

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\(^{78}\) 626.611
\(^{79}\) 732.703
• Securities or other registered accounts.

Unless otherwise provided through the marital separation agreement, any beneficiary designation that was imposed for the benefit of the spouse is rendered void in the case of a divorce or annulment. Florida law has always treated Wills and Revocable Trusts in this manner, but the new law now includes other revocable assets in the estate of the deceased. The law, in essence, treats the ex-spouse of the deceased as if the ex-spouse was the predecessor in death.

The statute does not, however, void a beneficiary designation under any of the following circumstances:

• If a federal or other state law provides otherwise;
• If the beneficiary designation was irrevocable;
• If the beneficiary designation was assigned after the divorce;
• If the beneficiary designation was court-ordered for the benefit of the ex-spouse or children;
• If the divorced parties remarry and remain married until the decedent’s death; and
• If the assets are held jointly.

The statute does not apply to assets held as joint tenants with right of survivorship, however. 80

**FINGERPRINTING**

MorphoTrust USA, formerly L-1 Enrollment, is the Department’s fingerprinting vendor. Applicants for licensure can make an appointment to get their fingerprints taken by visiting www.L1enrollment.com/FLInsurance. The fingerprinting fee is $50.30 and fingerprint results are valid for 12 months.

Fingerprint results are not shared with other agencies or other states and fingerprint results from other vendors or other states are not accepted. Two fingerprint cards are required and must be taken by an agency that has been previously approved by the Department. Fingerprints will be submitted electronically to the Florida Department of Law Enforcement and the results of

80 732.703
the subsequent criminal investigation will be sent electronically to the Department.

**CONTACT INFORMATION**

Licensee contact information changes must be sent to the Department within 30 days, as opposed to the previous 60-day requirement. Appointments cannot be renewed if the Department does not have a correct address on file for the licensee. Changes can be made through the licensee’s MyProfile account.

**MOVING OUT OF STATE**

If a licensee moves his or her principal place of residence and principal place of business out of the state of Florida, the Department will immediately terminate the individual’s license(s) and all appointments.

**SUMMARY OF ANNUITY UPDATES**

Previously, annuity suitability requirements concentrated on the senior consumer, age 65 or older. Suitability requirements have now been expanded to include any annuity transaction, no matter what the consumer’s age. The recommending agent must record recommendations made to the consumer. Suitability forms must be given to the insurer within 10 days and given to the consumer by the contract delivery date at the latest. If a consumer refuses to provide suitability information, the consumer must sign a statement attesting to that fact.

Suitability questions must be presented in at least 12-point type and be sufficiently clear so as to be readily understandable by both the agent and the consumer. Additional material added must not obscure the information required, or rearrange the required information in such a way as to make it more difficult to find or understand. Insurers are permitted to modify the form to use check-off boxes for indication of investment experience and risk tolerance, but must not substitute check-off boxes for any other items on the form.

Agents are prohibited from dissuading or attempting to dissuade a consumer from:

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81 626.551
82 626.551
83 69B-162.011, 627.4554(5)(b)
• Truthfully responding to an insurer’s request for suitability information;
• Filing a complaint; or
• Cooperating with the investigation of a complaint.  

Unconditional refund periods have been expanded from 14 days to 21 days.

Surrender charges cannot exceed 10% of the amount withdrawn—and must end after the tenth policy year or ten years after the premium is paid, whichever is later.  

Issuance of an annuity must be reasonable based on all the circumstances actually known to the insurer at the time the annuity is issued. However, an insurer does not have an obligation to a consumer related to an annuity transaction if a recommendation has not been made or if a recommendation was made and is later found to have been based on materially inaccurate information provided by the consumer. If the consumer decides to enter into an annuity transaction that is not based on the agent’s recommendation, the purchaser must sign a statement acknowledging that fact.

84 627.4554(5)(h)
85 627.4554(8)
CHAPTER 2 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence best?
(Answers are in the back of the text.)

1. Senate Bill 166 prohibits surrender charges in annuity contracts issued to a senior consumer from exceeding _____ of the amount withdrawn.
   a) 2%
   b) 5%
   c) 10%
   d) 20%

2. Suitability forms should be presented to the insurer within ______ after execution of the form.
   a) one week
   b) ten days
   c) two weeks
   d) one month

3. Senate Bill 166 expanded the unconditional refund period to _____ for all fixed and variable annuities.
   a) seven days
   b) ten days
   c) two weeks
   d) 21 days
ETHICAL REQUIREMENTS

Ethical behavior is contagious — The application of ethics within the corporate community lends a way to determine responsibility in business dealings. The identification of respected business and social issues leads to an improved society. Simply put, ethical standards define what is considered acceptable and unacceptable behavior, but the overall scope is much more intensive.

CODE OF ETHICS DFS

(1) The department shall, after consultation with the Florida Association of Insurance and Financial Advisors, adopt a code of ethics, or continue any such code heretofore so adopted, to govern the conduct of life agents in their relations with the public, other agents, and the insurers.

(2) The code of ethics shall apply standards of conduct designed to avoid the commission of acts or the existence of circumstances which would constitute grounds for suspension, revocation, or refusal of license under ss. 626.611 and 626.621 and to avoid the use of unfair trade practices and unfair methods of competition which would be in violation of any provision of part IX.

(3) All applicants for license as life agents shall subscribe to the code of ethics.86

Florida statutes declare the business of life insurance to be a public trust in which service all agents of all companies have a common obligation to work together in serving the best interests of the insuring public. Agents are called upon to accurately present every fact essential to a client’s decision, placing the policyholder’s interests first, and to be fair in all relations with colleagues and competitors.87

86 626.797
87 69B-215.210
FIDUCIARY RESPONSIBILITIES

A “fiduciary” is a person in a position of special trust and confidence. The term fiduciary refers to a relationship in which one person has a responsibility of care for the assets or rights of another person.

When a business relationship is entered into, both parties have expectations of a mutually beneficial relationship. The insurance professional should, at all times, place the interests of the client ahead of his or her own. When acting in a fiduciary capacity, the insurance professional owes his client or prospective client all of the following standards.

- **Establishing a Good Faith Relationship** — If any one party in a relationship cannot be seen by the other as generally acting in a good faith manner, a mutually successful relationship cannot exist.

- **Maintaining Loyalty** — Demonstrating loyalty means exercising a genuine feeling of strong support and faithfulness to commitments or obligations.

- **Skill and Care** — Insurance professionals must demonstrate responsibility to handle the client or prospective client’s needs in a proficient and scrupulous manner, thus enabling the client’s goals to be reached. In order to accomplish this, the client or prospective client must be represented in a skillful manner.

- **Full Disclosure** — Full disclosure is critical to the welfare of the client. Should any information remain undisclosed, the client cannot make a fully informed decision. Without having all the information at the client’s disposal, a fully informed decision cannot be made and, therefore, the client’s needs are not being serviced appropriately.

- **Timeliness** — Obligations are typically based on time schedules. Any paperwork generated from a presentation or recommendation should be submitted on a timely basis to limit the client’s risk of not achieving their goals as expected.

- **Accountability of Funds** — As in most cases and most business transactions, client funds should never be commingled with other funds, especially those of the individual serving in an advisory position.
- **Conflict of Interest** — Insurance professionals must act in all transactions to avoid any potential conflict of interest between himself, his client and the insuring entity involved. The highest priority is the obligation to the client or potential client – acting at all times with the client’s best interest in mind is paramount.

- **Proper Business Solicitation** — It is the insurance professional’s obligation to solicit only that business which represents the risk element that involved parties are willing to take.

- **Competitive Fair Play** — Any intentional false communication, either written or spoken, that harms a person’s reputation can be construed as defamation of character. Not only is defamation unethical it can, in certain situations, also be construed as a criminal act.

**POLICYHOLDERS BILL OF RIGHTS**

Florida statutes outline a Bill of Rights for policyholders that serve as standards to be followed by the Department of Financial Services in exercising appointed powers and duties. Policyholders have the right to:

- Competitive pricing practices and marketing methods that enable them to determine the best value among comparable policies;
- Obtain comprehensive coverage;
- Insurance advertising and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy;
- An insurance company that is financially stable;
- Be serviced by a competent, honest insurance agent or broker;
- A readable policy;
- An insurance company that provides an economic delivery of coverage and that tries to prevent losses; and
- A balanced and positive regulation by the Department, Commission, and Office.

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88 626.9641
**REQUIRED DISCLOSURE ON FORMS**

Every insurance application that is used by an agent is required to contain the name of the insurer in legible type on the front page of the application form. The form must also include the agent’s name and license number. Once the application is completed, a copy must be left with the prospective insured.

**TWISTING AND CHURNING**

“Twisting” is the practice of inducing a policyowner with one company to lapse, forfeit, or surrender an existing insurance policy for the purpose of taking out a policy in another company. The replacement of insurance through incomplete, misleading or inaccurate sales practices is illegal. An unfair or misleading comparison of two contracts is a disservice if it causes a customer to drop a policy they have had for some time in order to purchase another one that is no better or, perhaps, not even as good. Twisting is illegal, as well as unethical.

> “Twisting is declared to be unethical. No person shall make any misleading representations or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, or convert any insurance policy, or to take out a policy of insurance in another insurer.”

“Churning” is the practice by which policy values in an existing life insurance policy or annuity contract are used to purchase another policy or contract with that same insurer for the purpose of earning additional premiums or commissions without an objectively reasonable basis for believing that the new policy will result in an actual and demonstrable benefit.

If a person violates statutes governing twisting or churning, that person will have committed a first-degree misdemeanor and will be subject to an administrative fine up to $5,000 for each nonwillful violation or up to $75,000 for each willful violation. Administrative fees are limited by law to an aggregate amount of $50,000 for all nonwillful violations or an aggregate amount of $250,000 for all willful violations arising out of the same action.
**REBATING**

“Rebating” is the process of returning part of a commission or giving anything else of value to an insured as an inducement to purchase a policy. In most instances it is illegal, as well as unethical, and could be cause for license revocation.

“Rebating is declared to be unethical. Except as otherwise expressly provided by law, no person shall knowingly permit or offer to make or make any contract of life insurance, life annuity or disability insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or pay or allow, or give or offer to pay, allow, or give, directly or indirectly as an inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract.”

However, it may surprise you to know that rebating is allowed under certain strict guidelines—such as, the rebate must be available to all insureds in the same actuarial class; there must be no discrimination of any sort; and the rebate is in accordance with a rebating schedule filed by the agent with the insurer. Rebate schedules must be nondiscriminatory and uniformly applied, and must be prominently displayed in public view in the agent’s place of business.

**DEFAMATION**

“Defamation” is the malicious communication of a false statement that causes injury to another, either by slander (the spoken word) or by libel (the written word). Defamation of character can cause injury to one’s reputation, sometimes resulting in irreparable damage. Any intentional false communication, either written or spoken, that harms a person’s reputation can be construed as defamation of character. Not only is defamation unethical, it can also be considered a criminal act.

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91 69B-215.220, 626.572  
92 69B-215.220  
93 626.572  
94 69B-215.225
“Defamation is declared to be unethical and defined as making, publishing or circulating any oral, written or printed statement which is false, or maliciously critical of or derogatory to the financial condition of any insurance company, or which is calculated to injure any person engaged in the business of life insurance, and this practice is declared to be unethical.”

**MISREPRESENTATION**

“Misrepresentation” occurs when describing or presenting a product in an untrue manner—it is a form of deception, usually perpetrated to mislead someone into a purchase. In regard to insurance products, any statement, whether written or oral, that does not accurately describe a policy’s features, benefits or coverage is considered a misrepresentation.

(1) Misrepresentations are declared to be unethical. No person shall make, issue, circulate, or cause to be made, issued, or circulated, any estimate, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or make any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or make any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or use any name or title of any policy or class of policies misrepresenting the true nature thereof.

(2) No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, any advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

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95 69B-215.230
Misrepresentation does not necessarily occur deliberately—it may occur inadvertently. Following are some of the more common examples of situations in which misrepresentation can unintentionally occur:

- An agent is so enthusiastic about a product that he or she may overstate policy promises and guarantees; or
- Making claims that the agent believes to be true about the terms of a policy, or the financial condition of an insurer or other entity that are unsupported.

**USE OF DESIGNATIONS**

A professional designation is the appointment or selection of an individual for a distinguishing name or title that represents a certain specialty or post. The Department of Financial Services does not endorse any professional designations.

“A designation may not be lawfully used under the Insurance Code unless the designation is obtained from an organization that has published standards and procedures for assuring the competency of its certificants or designees on specific subject matters, which standards and procedures are continually utilized by the organization.”

Florida law with regard to the use of designations is designed to protect consumers from dishonest, deceptive, misleading and fraudulent trade practices in the marketing, solicitation, negotiation, sale or advice made in connection with an insurance transaction by any licensee.

The prohibition against the use of designations includes:

- Use of a designation by a person who has not actually earned or is otherwise ineligible to use such designation;
- Use of a nonexistent or self-conferred designation; and
- Use of a designation that indicates or implies a level of occupational qualifications obtained through education, training, or experience that the person using the designation does not have.

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96 69B-215.235
**UNLICENSED INSURANCE ACTIVITY**

Every licensee who has knowledge of unlicensed insurance activity is required to report such activity to the Department. In the case of unlicensed insurance activity by Multiple Employer Welfare Arrangements (MEWA), labor leasing organizations, and purportedly collectively bargained plans, the following information should be reported:

- Any known organizational information;
- Information on any insurance or reinsurance contracts, benefits or coverage offered;
- The names, addresses and phone numbers of any officers or agents; and
- The names, addresses and phone numbers of any employers, employees or individuals who may be enrolled by, or who will be receiving services from, the entity reported.

**MARKETING REGULATORY AND ETHICAL GUIDELINES**

In 2007, the Florida Financial Services Commission adopted a Rule to protect active duty service members of the U.S. Armed Forces from dishonest and predatory insurance sales practices in Florida.

The standards set forth are for the protection of military personnel with regard to the solicitation and sale of life insurance and annuity products by insurance producers. The Rule’s standards prohibit dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair. Any producer in violation of these provisions is subject to the procedures and penalties prescribed by Florida law.

If an insurance producer seeks to conduct the in-person, face-to-face solicitation of life insurance sales on a military installation, the following rules apply.

- Solicitations must be made on an appointment basis—“cold-calling” is prohibited.
- “Voluntary attendance only” is required for group solicitations.

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97 69B-230.033
98 69B-240.001
• Appointments must not be made during service members’ duty hours.
• Appointments cannot be solicited in “prohibited solicitation” areas.
• Permission for solicitation or the posting of bulletins, notices or advertisements must first be obtained from the installation commander or the commander’s designee.
• DD Form 2885, *Personal Commercial Solicitation Evaluation*, must be presented to solicited service members and those service members must not be dissuaded from completing the form.

The following are declared unfair or deceptive acts or practices when committed by an insurance producer with respect to the same in-person, face-to-face solicitation of life insurance on a military installation:

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

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

• *(j)* Participating or using another insurance producer to participate in any U.S. Armed Forces sponsored education or orientation program.

Regardless of the location where insurance sales may be made to an active duty service member, the following acts are prohibited.

• Offers of inducement are prohibited, either to the prospective insured or to any other personnel to assist in any inducement to obtain or to organize sales.

• Advising a service member to change his or her income tax withholding or state of legal residence for the sole purpose of increasing disposable income to purchase life insurance.

• Using any type of identifying instrument that would mislead the service member into believing that the insurer or product being offered is affiliated
or endorsed by any U.S. Government or federal agency, including the Armed Services.

- Implying that a policy’s credited interest rate is a net return on paid premiums, or indicating that life insurance is “free” or “costs nothing” due to mortality costs.

- Misrepresenting conversion requirements, coverage costs, policy limitations or exclusions.

- Recommending the cancellation or replacement of an existing Servicemembers’ Group Life Insurance (SGLI) policy unless the replacement’s effective date corresponds with the service member’s discharge date from the Armed Forces.

- Failure to disclose the true purpose behind establishing an in-person appointment for the sale of insurance.

- Failure to disclose the written disclosures required by Section 10 of the “Military Personnel Financial Services Protection Act.*”

- Failure to explain any free look period with instructions on how to cancel if a policy is issued and to leave a copy of the application or a written disclosure.

- Selling any life insurance product that excludes coverage if the insured’s death is related to any act that is in connection with military service, including war, except for accidental death coverage, e.g., double indemnity, which may be excluded.

*Note: Section 10 of the Military Personnel Financial Services Protection Act is: “Required Disclosures Regarding Life Insurance Products.”

UNDERSTANDING INDUSTRY PRODUCTS & SUITABILITY OF SALES AND SERVICES

It is the responsibility of the insurance producer to ensure that any product recommendation meets the objectives and means of the customer. Financial professionals have a duty to take steps to ensure that any recommended investment product is suitable for the client. The ability to maintain client relationships is one of the most valuable skills a professional can possess. In
order to maintain a mutually positive relationship, the agent has a duty to know the customer's needs, risk elements, objectives and goals.

- *Is the product appropriate for the client?*
- *Does the product adhere to the immediate needs of the client?*
- *Does the product coincide with the objectives and goals of the client?*
- *Does the client fully understand and accept the recommendation's limitations?*
- *Does the client fully understand the recommendation's coverages?*

It is the agent’s responsibility to place the interest of the client ahead of his or her own interests at all times. Clients and prospective clients should be treated fairly and professional services should be provided with integrity and objectivity.

The agent is responsible for:

- Defining the client’s goals, needs and objects;
- Gathering and providing appropriate data for any recommendations; and
- Examining the result of the current course of action without changes.

The agent should only offer advice in those areas in which he or she is competent to do so and must maintain competence in all areas for which he or she is engaged to provide professional services. Reaching suitability goals is a required objective, and maintaining those goals is vital to a mutually successful professional relationship.

**INCONTESTABLE CLAUSE**

Every insurance contract is subject to an incontestable clause, which places a time limit in which an insurer can dispute a policy based on the validity of statements made on an original application. In Florida, that period is two years. Once the two-year period has passed, an insurer cannot challenge the application. The incontestable clause does not, however, apply in cases of impersonation, lack of insurable interest or the intent to commit murder.99

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99 627.455
POLICY REPLACEMENT

“Replacement” is the act of replacing one insurance policy with another. The rules adopted for policy replacement are to safeguard the interests of persons who are considering replacing their existing insurance and to reduce the opportunity for misrepresentation or other unfair practices and methods of competition within the insurance industry.

An insurance application must contain a question as to whether the insurance to be issued is to replace any policy currently in force. If a replacement is indicated, the application must state the existing company name and policy number. A signed statement must be submitted to the insurer that indicates:

- The agent knows replacement is or may be involved in the transaction; and
- The applicant is aware the purchase of the new policy is meant to replace an existing life insurance policy, if such is the case.

When replacement is involved in the case of life insurance, the replacing agent must present to the applicant a “Notice to Applicant Regarding Replacement of Life Insurance.” The Notice must be signed by both the applicant and the agent and left with the applicant, along with the originals or copies of all sales material used during the presentation. A copy of all materials must also be submitted to the replacing insurer.

Section §151.201 outlines provisions with respect to unfair methods of competition and unfair or deceptive acts, specifically churning, and include the adoption of Form OIR-DO-1180. The disclosure form applies to all types of policies that include a policy value feature. The form details the following information.

- Part A — Current Policy Information
- Part B — Proposed Policy Information
- Part C — Source of Funding for the Proposed Policy
- Part D — Your Current Policy Could Terminate

UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS

Florida Statutes, Sections §626.951 through §626.99, govern unfair insurance trade practices. Engaging in any trade practice, unfair method of competition,
and unfair or deceptive act of practice involving the business of insurance in the state of Florida is prohibited. The Department retains the power to examine and investigate the affairs of every person involved in the business of insurance within the state in order to determine whether that person has been engaging in any unfair method of competition or unfair or deceptive act or practice.\footnote{626.9561}

Violators of these statutes are subject to a fine of up to $5,000 for each nonwillful violation and up to $40,000 for each willful violation. Fines against an insurer may not exceed an aggregate amount of $20,000 for all nonwillful violations and $200,000 for all willful violations arising out of the same action.\footnote{626.9521(2)}

If an application or any other policy-related document is submitted containing fraudulent signatures, the penalty is a third-degree felony and the violator is subject to administrative penalties up to $5,000 for each nonwillful violation and up to $75,000 for each willful violation. Administrative fines are limited to an aggregate amount of $50,000 for all nonwillful violations and $250,000 for all willful violations arising out of the same action.\footnote{626.9521(3)}

As you already know, any advertising materials used in the solicitation of insurance sales must clearly indicate that the communication relates to insurance products and agents must clearly indicate that they are acting as insurance agents.

Florida law defines the following as unfair methods of competition and unfair or deceptive acts or practices.

- **Misrepresentation and false advertising of insurance policies** — The act of making, issuing, circulating, or causing to be issued or circulated, an estimate, illustration, circular or statement of any kind that does not represent the correct policy terms, dividends, or share of the surplus or the name or title for any policy or class of policies that does not in fact reflect its true nature. When an agent purports to knowledge that he or she does not possess, that agent is guilty of misrepresentation.

- **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 through any means any information that is untrue in any way in connection with insurance.

- **Free insurance prohibited** — Free insurance is insurance for which no identifiable and additional charge is made to the purchaser for property or services or insurance for which an identifiable or additional charge is made in an amount less than the cost of such insurance. Using the word “free” or other words that imply insurance at no cost in connection with advertising is prohibited.\(^{103}\)

In addition, unfair methods of competition and unfair or deceptive acts include any tactic involving the following:

- Defamation;
- Boycott, coercion and intimidation;
- False statements and entries;
- Offering illegal inducements or advertising gifts (for the purposes of advertising, any article of merchandise having a value of not more than $25 is permitted);
- Unlawful rebates;
- Unfair claim settlement practices;
- Failure to maintain complaint-handling procedures;
- Twisting and Churning;
- Illegal dealings in premiums; excess or reduced charges for insurance;
- “Price packaging” in insurance costs;
- Certain insurance transactions through credit card facilities;
- Interlocking ownership and management;
- Prohibited arrangements as to funerals;
- Certain life insurance relations with funeral directors;
- False claims – obtaining or retaining money dishonestly;
- Failure to provide required proposals to a prospect;
- Soliciting or accepting new or renewal insurance risks by insolvent or impaired insurers;

\(^{103}\) 626.9541
Unfair discrimination – illegal refusal to insure (i.e., on the sole basis of race, color, creed, marital status, sex or national origin);

- Requiring, as a condition of the purchase or continuation of an insurance policy, a power of attorney;
- Sliding;
- Deceptive use of a name;
- Unfair rate increases for persons in military service;
- Limiting life insurance based on past or future foreign travel experiences;
- Fraudulent signatures on an application or policy-related document; and

**POWER OF THE DEPARTMENT AND OFFICE**

The Department retains the power within its respective regulatory jurisdiction to examine and investigate the affairs of every “person” involved in the business of insurance within the state of Florida in order to determine whether that person has been or is engaged in any unfair method of competition or in any unfair or deceptive act of practice.

“‘Person’ means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, or business trust or any entity involved in the business of insurance.”

Within their authority, the Department may conduct or cause to have conducted a hearing in accordance with Florida’s *Administrative Procedure Act*, and impose lawful penalties. Penalties for failure to comply with a subpoena or with an order of discovery issued by the Department are punishable by a fine of up to $1,000 per violation.

**ILLEGAL DEALINGS IN LIFE OR DISABILITY INSURANCE**

Insurers are prohibited from refusing to renew, sell or issue a life or disability insurance policy, or establish or charge a premium or rate solely on the basis of an individual suffering from a severe disability.

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104 626.9511
105 626.9571
106 626.9705, 626.9706, 626.9707
“Severe disability,’ as used in this section, means any spinal cord disease or injury resulting in permanent and total disability, amputation of any extremity that requires prosthesis, permanent visual acuity of 20/200 or worse in the better eye with the best correction, a peripheral field so contracted that the widest diameter of such field subtends an angular distance no greater than 20 degrees, or neurosensory deafness.”

Insurers are also prohibited from refusing to issue any policy of life insurance, or charge a higher premium rate, based solely on the fact that the prospective insured has the sickle-cell trait.

**LIFE INSURANCE SOLICITATION**

Rules set forth are, in effect, to improve a policy buyer’s ability to select the most appropriate plan of life insurance, improve the buyer’s understanding of the basic features of the policy, and improve the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

At the onset, the insurance solicitor must make his or her intentions known to the prospective insured. The full name of the insurance company being represented must be provided prior to the sales presentation. The use of terms such as “financial planner,” “investment advisor,” “financial consultant,” or “financial counseling” is prohibited if those terms are used in such a way to mislead the consumer into believing that the agent is acting solely on an advisory basis without compensation.

Any reference to policy dividends must include a statement advising the prospective insured that dividends are not guaranteed. A presentation of benefits containing guaranteed and nonguaranteed figures must not be commingled, but must be clearly demonstrated in separate columns for clarity. When conducting policy comparisons, the value of “future dollars” vs. “today’s dollars” must be made clear to the prospect.

Agents are required to deliver to an applicant a Life Insurance Buyer’s Guide and a Policy Summary. The buyer’s guide is an informational consumer guidebook that explains insurance policies and insurance concepts. The policy summary addresses the specific product being presented, identifying the agent, the insurer, the policy and each rider—including premium information, dividends,

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107 626.99
benefit amounts, cash surrender values, policy loan interest rates and life insurance cost indexes. These documents are usually delivered before the applicant’s initial premium is accepted. However if the policy provides an unconditional refund period of at least 14 days, the buyer’s guide and policy summary must be delivered with the policy or prior to delivery of the policy. Buyer’s guides and/or policy summaries must be provided to any prospective purchaser upon request. Failure to deliver a buyer’s guide or a policy summary constitutes an omission, which misrepresents the benefits, advantages, conditions or terms of an insurance policy.

All records and copies of each document used during a presentation and sale for any transaction involving premium payments must be kept for a period of three years.

**Annuity Solicitation**

All fixed and variable annuity policies must contain an unconditional refund clause. The unconditional refund must be equal to the annuity’s cash surrender value plus any fees or charges deducted from the premiums or imposed under the contract. The unconditional refund period must be clearly displayed on the annuity’s cover page, along with the issuing company’s and the agent’s contact information and the Department’s toll free help line number.

**Understanding Premium Discounts**

Most insurers offer discounts. It is one of the best ways to get and retain business—and it’s one of the best ways for insurance companies to spread their risk. Chances are if the insured has a claim on one policy, they will not have a claim on one of the others under their multi-policy discount plan.

As you know, premium rates are set on a “risk basis.” Principal factors that determine premium rates are:

- Age,
- Gender,
- Health,
- Occupation and avocation, and
- Personal lifestyle choices and habits.

**Age** — Mortality risk increases in conjunction with a person’s age. Health typically declines with age and life span is shortened. The younger the individual,
the longer the premium-paying period is and the longer the cash accumulation period is.

**Gender** — It is a known fact that females live longer than males—on average, four to five years. Therefore, males present a higher mortality risk than females. Women may pay higher medical premiums because women are more likely to visit the doctor more often and, of course, women are the only ones who can get pregnant. A delivery alone, without complications, costs on average $18,000.

**Health** — The longer a person is in good health, the lower the mortality risk. For instance, individuals who have a high body mass index (BMI) can incur significantly higher rates—being overweight can definitely affect an individual’s risk profile.

**Occupation or Avocation** — One person’s job may be more dangerous than another’s. Consider a school teacher vs. an airline pilot—insuring which represents the greater risk?

**Lifestyle Choices and Habits** — Humans are, by nature, “creatures of habit.” We all have some sort of habitual behavior—some good and some bad. Smoking, for instance, can cause major health hazards and therefore smokers represent a higher risk to insurers. Most insurers give discounts for non-smoking individuals and discounts for those who have quit smoking for a certain period of time. It takes a while for the effects of long-term cigarette smoking to lessen the risk of illness or disease that is typically associated with smoking, so some insurers may still consider insureds as “smokers” even though they haven’t smoked in a few years.

**Family History** — Individuals who have a family history of certain medical conditions may pay higher premiums. A person who has a family history of cancer, for instance, presents a higher risk to the insurer.
CHAPTER 3 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence best?
(Answers are in the back of the text.)

1. Every insurance application that is used by an agent must contain:
   a) the name of the insurer.
   b) the agent’s name.
   c) the agent’s license number.
   d) All of the above.

2. In Florida, an insurance policy’s incontestable clause is:
   a) 60 days.
   b) one year.
   c) 18 months.
   d) two years.

3. Rebating is permissible if:
   a) the agent is behind on writing business.
   b) a nondiscriminatory rebate schedule has been filed with the insurer.
   c) the client purchases collateral business.
   d) the agent needs to increase his or her client base.
CHAPTER 4

DISCIPLINARY AND INDUSTRY TRENDS

RECENT VIOLATIONS & ENFORCEMENT ACTIONS

Insurance fraud costs the United States approximately $80 billion dollars a year. In Florida, the Division of Insurance Fraud (DIF) is responsible for investigating all types of insurance fraud and ranks in the top five among all states’ fraud bureaus and divisions.

A person commits a “fraudulent insurance act” if that person:

“Knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, self-insurer, self-insurance fund, servicing corporation, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a claim for payment or other benefit pursuant to any insurance policy, which the person knows to contain materially false information concerning any fact material thereto or if the person conceals, for the purpose of misleading another, information concerning any fact material thereto.”

The DIF compiles annual statistical reports, called STAT PACKs that provide accounting for referrals, cases, types of fraud, etc. The Division’s 2012-2013 STAT PACK reported 138 convictions of the 141 arrests concerning licensee fraud. The majority of complaints were aimed at agents, the highest category of complaints in regard to unlicensed agents or adjusters. Licensee convictions ranked the third highest of all reported arrests and convictions (third only to personal injury protection and workers’ compensation). In regard to life insurance fraud, 24 of the 33 complaints lodged concerned beneficiary forgery.

DFS INSURANCE FRAUD REWARDS

The Department of Financial Services working in conjunction with the DIF implemented an Anti-Fraud Reward Program to entice individuals to report fraudulent activity. The Department may pay rewards of up to $25,000 to persons
who provide information leading to the arrest and conviction of persons committing crimes investigated by the DIF. Since the inception of the reward program, the Department has paid out more than $250,000 in reward monies for more than $16 million in potential insurance fraud losses.

Since reporting of such activity is required of all licensed individuals and entities, the Anti-Fraud Reward Program is only available to those unlicensed.

**INSURER ANTI-FRAUD INVESTIGATIVE UNITS**

Every licensed insurer in this state who collected $10 million in direct premiums at anytime during the previous calendar year is required to establish and maintain an internal unit for the investigation of possible fraudulent claims by or on behalf of insureds. Rather than housing an internal unit, Florida law permits insurers to contract with third parties to conduct such investigations.

Insurers who had less than $10 million in direct premiums written within the previous year must adopt an anti-fraud plan and file it with the DIF. Insurer anti-fraud plans must include:

- A description of the insured’s procedures for detecting and investigating possible fraudulent insurance acts;
- A description of the insured’s procedures for the mandatory reporting of possible fraudulent insurance acts to the DIF;
- A description of the insured’s plan for anti-fraud education and training of its claims adjusters or other personnel; and
- A written description or chart outlining the organizational arrangement of the insured’s anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts.

Any insurer who obtains a Certificate of Authority after July 1, 1995, has 18 months in which to comply with these anti-fraud requirements. Failure to do so could result in an administrative fine of up to $2,000 per day.

**CEASE AND DESIST**

Any individual that has engaged in an unfair or deceptive act or practice or the unlawful transaction of insurance, in addition to any other applicable penalties and fines, may also be subject to a cease and desist order by the Department. Failure to honor a cease and desist order can lead to an administrative penalty of
up to $50,000 and suspension or revocation of the person’s license or eligibility to hold a license.

The Department may issue a cease and desist order if they have reasonable cause to believe that the subject is engaging in or has engaged in conduct that is an act that demonstrates a lack of fitness or trustworthiness to engage in the business of insurance, is hazardous to the insurance buying public, or constitute business operations that are a detriment to policyholders, stockholders, investors, creditors or the public. Any of the following acts may also be subject to a cease and desist order:

- A violation of any provision of the Florida Insurance Code;
- A violation of any rule of the Department;
- A violation of any order of the Department; and
- A breach of any written agreement with the Department.

Any person who knowingly transacts insurance or otherwise engages in insurance activities in the state of Florida without a license, or while the license(s) is suspended or revoked, commits a felony of the third degree.

**DFS BUREAU OF INVESTIGATION**

The Department of Financial Services’ Bureau of Investigation recovered $5,789,589 in 2013 to return to Florida citizens. Nearly $2 million recovered went to senior citizens.

One of the most financially significant cases investigated resulted in a payment of $700,000 in restitution to 123 individuals and small businesses. Investigators uncovered a scheme in which insurance agents specializing in surplus lines risks were found to be over-charging their clients far above the standard commission they earned on commercial surplus lines accounts.

**RECENT ENFORCEMENT ACTIONS**

As you’ve already learned if the Department finds reason for suspension or revocation of a license or appointment, the Department will specify the term of suspension, up to two years.

Following are actual cases of agents and agencies that violated the Insurance Code and the repercussions they incurred.
**Aiding and Abetting**

This first case was adjudged in February 2016, resulting in a six-month license suspension for knowingly aiding and abetting an unlicensed person in the sale and solicitation of insurance. The licensee made material misrepresentations on multiple applications submitted to the insurer. He was also found guilty of failure to properly license his insurance agency in a timely manner.

As a result, his license and eligibility for licensure and appoints were suspended. He will be eligible to file an application for reinstatement of licensure after the end of the six-month suspension.

**Willful Deception**

This next case resulted in the permanent surrender of licensure as a life, health and variable annuity agent. The Department’s investigation determined that the licensee used willful deception in the submission of multiple supplemental health insurance policies without the knowledge and consent of the proposed insureds.

No monetary penalties were assessed; however, the licensee’s ability to possess an insurance license or to be affiliated with any licensed entity in order to conduct insurance business was permanently removed as of January 2016.

**Multiple Violations**

This case occurred in February 2014 and involved a Life, Health and Variable Annuity agent. A five-count Administrative Complaint was issued against the agent and the agency he owned and operated alleging that the agent and the agency sold self-insured insurance plans, misrepresenting them to be fully insured, fixed costs, health insurance plans. In the process, he submitted fraudulent documents with falsified signatures and altered language so that the insured became liable for all claims in excess of premiums paid on the policies. He also failed to forward clients’ premium payments to the insurer, which resulted in cancelled insurance coverages. Instead, the agent deposited the payments into his own bank accounts. Checks he wrote on his accounts to cover premium payments were returned for insufficient funds.

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108 Case #186163-16-AG  
109 Case #185395-16-AG  
110
The agent was found guilty of multiple violations, including: Reporting and accounting for funds; willful misrepresentation and deception, lack of fitness and trustworthiness, fraudulent and dishonest practices, and misappropriation; violation of the Insurance Code; unfair methods of competition; misrepresentation and false advertising; and the use of false statements and entries.\textsuperscript{111}

The agent further failed to answer the Administrative Complaint or request a hearing, and the Department entered an Order of Revocation. Based upon the Findings of Fact adopted in the Order of Revocation, the Department concluded that the agent and the agency violated the pertinent statutes and rules and ordered the revocation of all of the agent's and agency's licenses, appointments and eligibility for licensure. The revocation was ordered for a period of two years. After the two-year period, the Department will not grant a new license or appointment or reinstate eligibility to hold such license or appointment if it finds that the circumstance(s) for which the license was revoked still exist or are likely to recur.

During the period of revocation, neither the agent nor the agency can engage in or attempt or profess to engage in any transaction or business for which a license or appointment is required under the Florida Insurance Code or directly or indirectly own, control, or be employed in any manner by any insurance agent or agency. The agent and agency were also ordered to return all licenses to the Department within ten (10) calendar days of the issuance of the order.

\textbf{Acting Without Licensure}

In another case, an unlicensed individual was sentenced to 34 months in prison followed by 25 years’ probation. The individual who represented himself as an insurance agent defrauded two seniors out of nearly $490,000 in life insurance premiums. The fictitious agent met the seniors after making presentations at a local church. The two were offered a return of their principal through the sale of life insurance policies in their names that were to be sold as a part of a STOLI transaction. Premium payments made by the victims, however, were never sent to an insurance company and were, instead, deposited in the "agent's" own personal account. The fictitious agent was also ordered to pay full restitution to the victims.

\textsuperscript{111} 626.561(1), 626.611(5)(7)(9)(10), 626.621(2), 626.9521(1), 626.9541(1)(a)(ee)
**MISAPPROPRIATION OF FUNDS**

In yet another case, a former high school baseball coach scammed his fellow coaches, teachers and parents out of roughly $200,000 in a Ponzi scheme. The ex-coach represented himself as a registered investment dealer and collected monies from investors with the alleged purpose of investing in the stock market. Instead, the funds were placed in his personal accounts and used to pay previous investors and for his own personal expenses. He was arrested on nearly three dozen felony charges for defrauding investors in Florida.

**FAILURE TO REPORT ADMINISTRATIVE ACTIONS**

A licensed Life, Health, and Variable Annuity agent was barred by FINRA from associating with any FINRA member firm in any capacity, which constitutes grounds for revocation according to Section 626.621(13). In addition, he failed to report the administrative action to the Department within the required 30 days after the final the disposition. In order to avoid formal litigation, he determined that it was in his best interest to enter into a Settlement Stipulation for Consent Order.

By failing to report the administrative action, he violated Section 626.536 and his license was revoked. He will also be ineligible to reapply for licensure for a period of two years.

**FAILURE TO PAY ADMINISTRATIVE PENALTIES**

A licensed life and variable annuity agent’s license was suspended for 60 days for failure to pay a previously assessed administrative penalty of $1,500. Failure to pay an administrative penalty is a violation. She will have 60 days to file an application for reinstatement of licensure at which time she will also have to pay the administrative penalty.

**NONRESIDENT APPLICATION DENIED**

This case involves a South Carolina licensee who applied for licensure as a nonresident life and variable annuity agent and a nonresident health agent in Florida. The applicant failed to disclosure on his application administrative action that had previously been taken against him.

During the applicant investigation process it was found that the South Carolina Department of Insurance had entered into a Consent Order with the applicant imposing an administrative penalty of $2,500 for submitting approximately
13 insurance applications containing erroneous information. The Administrative Complaint alleged that he prepared bogus life insurance applications, altered portions of legitimate insurance applicants, and forged insured’s signatures on insurance applications and forms.

After the Florida denial for licensure, the agent applied to the Idaho Department of Insurance for licensure as a nonresident producer. Based upon the Florida and South Carolina administrative actions, the Idaho Department of Insurance denied his application.

**AGENT REGULATION AND FAILURE TO REMIT PREMIUMS**

A licensed agent recently had her licensed suspended for a period of 12 months for failure to remit premiums collected in the normal course of business to the insurer. The Department found that she violated Section 626.611(10) “Misappropriation, conversion, or unlawful withholding of moneys belonging to insurers or insureds or beneficiaries or to others and received in conduct of business under the license or appointment.” She also failed to submit a change of business address as required within 30 days to the Department. In addition to the license suspension, restitution in the amount of $7,173.59 was ordered to be paid to the insurer.\(^{112}\)

**TAX FRAUD\(^\text{113}\)**

An applicant was denied licensure and permanently barred from applying for an insurance license for filing a false tax return—a felony. Prior to applying for licensure with the Department, he had pled guilty to the charge of filing a false tax return and was subsequently adjudicated guilty, sentenced to three years probation and ordered to pay an assessment. On his application for licensure he answered “No” to the question:

“Have you ever been convicted, found guilty, or pled guilty or nolo contendere (no contest) to a felony under the laws of any municipality, county, state, territory or country, whether or not adjudication was withheld or a judgment of conviction was entered?”

\(^{112}\) 626.551, 626.611(10)

\(^{113}\) 626.207, 626.611, 120.57
It was determined he was guilty of violating Section 626.207(3) and, therefore, permanently barred from applying for insurance licensure in the state:

“An applicant who commits a felony of the first degree; a capital felony; a felony involving money laundering, fraud, or embezzlement; or a felony directly related to the financial services business is permanently barred from applying for a license. This bar applies to convictions, guilty pleas, or nolo contendere pleas.”

**Lack of Fitness or Trustworthiness**

In a case of agent regulation, the Department conducted an investigation into an agent’s capacity as a licensee. The agent was licensed as a Life and Variable Annuity agent, a Life, Health and Variable Annuity agent, a Life agent, and a Life and Health agent. As a result of the investigation, the Department found that the agent demonstrated a lack of fitness and trustworthiness to engage in the business of insurance. In order to avoid formal litigation in the matter, the agent determined that it would be in his best interest to enter into a settlement and waived his right to a hearing. He was ordered to pay an administrative penalty in the amount of $5,000 within the mandatory thirty-day time period. Failure to pay the administrative penalty within the specified time limit would result in the immediate suspension of his licenses and eligibility for licensure in the state without further proceedings for a period of sixty 60 days.

**False Advertising**

This case involved an individual who is licensed as a Life and Variable Annuity agent, a Life, Health and Variable Annuity agent, a Life agent, a Life and Health agent, and a Health agent. Through the course of the Department’s investigation into the agent’s capacity as a licensee, the Department found that the agent placed advertising that was misleading to the public and operated an insurance agency prior to being licensed.

An administrative penalty of $1,500 was imposed and the agent was placed on probation for a period of one year. If the agent violates the terms of probation, the agent’s licenses and appointments will be subject to suspension or revocation.

114 626.611(7)
115 626.112(7)(a), 626.9541(1)(b)
Unauthorized Products & Entities

The Department reminds agents to ensure the insurance companies they consider representing are authorized in Florida, before offering their products to consumers. DFS will open investigations on any Florida-licensed agents who are suspected of placing risks with unauthorized entities. Any agent who solicits or sells for an unauthorized entity may be liable for losses sustained not paid by the unauthorized entity, and may be charged with a third-degree felony punishable by imprisonment for up to five years and a fine of up to $5,000 on the first offense. Any licensed individual or entity that has knowledge of or suspects insurance activity by an unauthorized entity is compelled to report such activity or suspicions to the Department.

To make agents aware of the problems caused by unauthorized insurers, the Department requires the following notice to be included in all insurance education courses.

“An entity that is required to be licensed or registered with the Florida Office of Insurance Regulation but is operating without the proper authorization is identified as an unauthorized insurer. All persons have the responsibility of conducting reasonable research to ensure they are not writing policies or placing business with an unauthorized insurer. Any person who, directly or indirectly, aids or represents an unauthorized insurer can lose their licenses or face other disciplinary sanctions. Please see Section §626.901, Florida Statutes, to read the laws. Lack of careful screening can result in significant financial loss to Florida consumers due to unpaid claims and/or theft of premiums. Under Florida law, a person can be charged with a third degree felony and also held liable for any unpaid claims and refund of premiums when representing an unauthorized insurer. It is the person’s responsibility to give fair and accurate information regarding the companies they represent.”

The Department expects agents to verify whether an insurer is authorized before placing business with them. Even though an agent may have placed business with one insurer in the past does not mean that entity has remained authorized. The DFS website contains a company search link that agents can use to verify a company’s authorization status. Go to http://www.floir.com/CompanySearch and click on the “Search” button.

The following authorization types confer authority:

- Certificate of Authority (for admitted stock or mutual companies);
• Information Only;
• Letter of Approval;
• Letter of Eligibility (for approved surplus lines carriers);
• Letter of Registration;
• License;
• Provisional Certificate of Authority; and
• Residual Market.

Insurance companies whose authorization status is “Active” and authorization type is “Permit” means that the company has only begun the authorization process and is, therefore, not presently authorized to conduct insurance business. If a company the agent is seeking to research is not listed on the Department’s website, one should assume the company is not authorized.

**RED FLAGS**

There are always warning signs. Insurance agents and insurance entities must exercise due diligence and uphold their fiduciary responsibility to consumers—Pay Attention! The Department will not accept excuses such as “I was told it was authorized” or “I’m a victim because I was fooled into believing they were authorized” as legitimate defenses.

Following are some of the warning signs that an agent can look for:

• Relatively inexpensive premium rates when compared to other comparable policies;
• No variation in premium quotes for different applicants;
• If the company requires applicants to join an association or union to obtain coverage; and
• If the company’s name is ever-so-slightly different from one that is authorized.

Agents who, directly or indirectly, aid or represent an unauthorized insurance company can lose their agent license(s) or face other disciplinary sanctions. Possible consequences for aiding and abetting an unauthorized insurer are:

• Conviction of a third-degree felony;
• Liability for all unpaid claims; and
Suspension or revocation of all insurance licenses.

NEW AND OTHER IMPORTANT TERMINOLOGY

Throughout the studies of this course material, you have been re-introduced to many relatively familiar subject matters—and introduced to many new items and changes to law as well. The following will provide a brief refresher for those items previously studied and a brief encounter with new items that we have left untouched until now.

ADVERTISING

An advertisement for a policy providing benefits for specified illnesses only must clearly and conspicuously in prominent type state the limited nature of the policy. The statement must be worded in language identical or substantially similar to the following.

- THIS IS A LIMITED POLICY
- THIS IS A CANCER ONLY POLICY
- THIS IS A NURSING HOME COVERAGE ONLY POLICY

No advertisement can contain or use words or phrases in any manner that exaggerates any benefits beyond the terms of the policy.

CHIEF FINANCIAL OFFICER (CFO)

The Chief Financial Officer heads the Department of Financial Services, maintaining and exercising the power to investigate insurance companies and producers doing business within the state of Florida.

DISCLOSURE REQUIRED

All insurance applications must have the insurer's name displayed in a legible manner (typed, printed, stamped, or handwritten) on the first page of the application form at the time coverage is bound or at the time the premium is quoted. The application must also disclose the name and license identification number of the agent.
THE DODD-FRANK ACT

The Dodd-Frank Act brought comprehensive regulation to financial institutions through the:

- Identification of risks to the financial stability of the U.S. from both financial and non-financial organizations;
- Promotion of market discipline, by eliminating expectations that the government will shield them from losses in the event of failure; and
- Responding to emerging threats to the stability of the U.S. financial system.

EAPPOINT

Appointment applications must be submitted electronically through the Florida Department of Financial Services Producer Appointment System. Through eAppoint, licensees can send appointment-related submissions to the Department.

FLORIDA CODE OF ETHICS

The Florida Code of Ethics apply standards of conduct designed to avoid the commission of acts or the existence of circumstances which would constitute grounds for suspension, revocation, or refusal of license and to avoid the use of unfair trade practices and unfair methods of competition.

FINANCIAL SERVICES COMMISSION

The Financial Services Commission’s purpose is to safeguard the public by regulating the banking, securities, and insurance industries.

- The Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities.
- The Office of Financial Regulation (OFR) is responsible for regulating Florida’s banking, finance and securities industries.

FLORIDA HEALTH CHOICES

Florida legislators recognized the need for small employers and individuals to more easily navigate the landscape of health insurance and health services.
Florida Health Choices was established with the goal of increasing access to affordable, quality health care by creating a competitive market for purchasing health insurance and services. The program is administered by a 15-member board made up of appointees chosen by the Governor, the Senate president, and the House speaker.

**INCONTESTABLE Clause**

In Florida, the incontestable period is two years. The incontestable clause does not apply in cases of impersonation, lack of insurable interest or the intent to commit murder.

**INSURER ANTI-FRAUD INVESTIGATIVE UNITS**

Every licensed insurer in this state who collected $10 million or more in direct premiums at anytime during the previous calendar year is required to establish and maintain an internal unit (or contract with a third party) for the investigation of possible fraudulent claims by or on behalf of insureds. Insurers who had less than $10 million in direct premiums written within the previous year must adopt an anti-fraud plan and file it with the DIF.

**LAW ENFORCEMENT Records**

If the Department discovers that an applicant failed to accurately and truthfully answer any question relating to the Law Enforcement Records after a license has been granted, the Department will suspend or revoke each license currently held by the licensee.

**PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)**

The PPACA requires insurers to cover all applicants within minimum standards and offer the same rates regardless of preexisting conditions or gender.

**NAVIGATOR**

Navigator is a new category of insurance professional created to assist health insurance consumers to find insurance coverage through insurance exchanges. The position of navigator was created to fulfill mandates imposed by the PPACA.

Navigators are prohibited from:
• Soliciting, negotiating, or selling health insurance;
• Recommending the purchase of a particular health plan or represent that one health plan is preferable over any other;
• Recommending or assisting with the cancellation of insurance coverage purchased outside the exchange; and
• Receiving compensation or anything of value from an insurer, health plan, business, or consumer in connection with performing activities as a navigator, other than from the exchange or an entity or individual who has received a navigator grant under the PPACA.

**RISK BEARING ENTITY**

A risk bearing entity is a reciprocal insurer, a commercial self-insurance fund, a group self-insurance fund, a local government self-insurance fund, a self-insured public utility or an independent educational institution self-insurance fund.

**SUITABILITY INFORMATION**\(^{116}\)

Agents must have an objective standard to measure the suitability of a recommendation. There are many variables to consider when determining suitability. The issue of suitability is one of the most important factors for the benefit of those for whom the agent provides services. Reaching suitability goals is a required objective, and maintaining those goals is vital to a mutually successful professional relationship.


Senior suitability forms are available on the Division of Insurance Agent and Agency Services website at [www.myfloirdacfo.com/Division/Agents/Licensure/Forms](http://www.myfloirdacfo.com/Division/Agents/Licensure/Forms).

In a joint annuity transaction, if one of the individuals involved in the transaction is age 65 or over, both are considered senior consumers.

\(^{116}\) 69B-162.011, effective 10/01/2013
UNCONDITIONAL REFUND PERIOD

The unconditional refund period for all fixed and variable annuity purchases has been expanded to 21-days from the previous 14 days, regardless of the purchaser’s age.

USE OF DESIGNATIONS

The Department does not endorse any professional designations. A designation may not be lawfully used under the Insurance Code unless the designation is obtained from an organization that has published standards and procedures for assuring the competency of its designees on pertinent subject matters.
CHAPTER 4 REVIEW QUESTIONS

Which of the following answers/completes each question/sentence best?
(Answers are in the back of the text.)

1. Any agent who knowingly transacts insurance in the state of Florida while his or her license is suspended:
   a) commits a third-degree felony.
   b) will have their license revoked.
   c) will not receive any associated commissions.
   d) will lose his or her appointment.

2. Insurance companies whose authorization status is “Active” and authorization type is “Permit” means that the company:
   a) is fully authorized to conduct insurance business.
   b) is new.
   c) has only begun the authorization process and is, therefore, not presently authorized to conduct insurance business.
   d) is permitted to conduct active insurance business.

3. When checking a company’s authorization to conduct insurance business within the state of Florida, if the company’s name is slightly different from one that is authorized:
   a) it probably means they are affiliated and, therefore, authorized.
   b) the agent should see this as a red flag and further investigate the company’s authority.
   c) it probably means they are new.
   d) it probably means there was a clerical error.

4. When it comes to annuity suitability and disclosure in a joint transaction, if one individual is age 65 or older:
   a) both parties are considered seniors.
   b) neither party is considered a senior consumer.
   c) only the youngest individual can sign the contract.
   d) only the oldest individual can sign the contract.
ANSWERS TO CHAPTER REVIEW QUESTIONS

Following are the correct answers to the chapter review questions—listed by chapter, question number, the correct answer, and the section where the answers can be found within the course material.

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