

The Florida Office of Insurance Regulation (Office) developed the following worksheet to assist companies in drafting and submitting a Medicare Supplement Contract for review by the Office. The Office encourages, but does not require, the company to download, complete, scan, and upload this form as part of the form filing as it will expedite the review process. **The Office offers this worksheet as guidance only and it should not be considered a directive by the Office. The worksheet does not contain all of the requirements for Medicare Supplement filings, but instead incorporates guidance for point of law frequently overlooked in filings.**

**MEDICARE SUPPLEMENT CONTRACT WORKSHEET**  
**Individual and Group**  
**Standard and Select Plans**

STATUTE/RULE	FILING COMPLIANCE	YES	NO	N/A	PAGE #
	<b>MEDICARE SUPPLEMENT FILING REQUIREMENTS</b>				
69O-149.021	Required information to be submitted within the filing.				
69O-149.023(4)	Include a description of the distribution system (e.g., direct marketing, agents, financial institutions, etc.) and intended target population.				
69O-149.021(6)(c)	If not submitted already, the Office will ask for form number(s), date(s) of approval, Florida file number(s), (e.g. FLH 01-23456), and type of coverage of all policies or other related forms to be used or issued in connection with the form(s) submitted.				
627.4145(3)	Certification of Readability signed by an officer of the company.				
627.602(1)(d)	Requires at least 10-point type.				
627.602(1)(f)	All contracts and related forms shall contain a form number in the lower left-hand corner.				
69O-156.012	Filing & Approval of Policies and Certificates and Premium Rates.				
627.674	Minimum Standards; filing requirements				
	<b>POLICY / CERTIFICATE COVER PAGE</b>				
624.603 69O-154.001	Important Notice must appear in a prominent manner. The insured must notify the company within 10 days of any incomplete or incorrect information on the application.				
69O-156.014(1)(a)	Required Disclosure Provision: the renewal or continuation provision shall be appropriately captioned and on the first page of the policy/certificate. Shall include any reservation by the insurer to change premiums.				
69O-156.014(1)(e)	Required Disclosure Provision: The 30 day free look prominently printed. Upon receipt of policy or certificate the premium shall be refunded if insured person is not satisfied for any reason.				
69O-156.016(1)(c)	Required Disclosure Statement: Display prominently the following: "Notice to buyer: This policy may not cover all of your medical expenses."				

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627.602(2)	If the contract has a deductible provision, it should be on the first page of the policy/certificate in at least 18-point type.				
	<b>POLICY / CERTIFICATE CONTENTS</b>				
627.413(1)(b)	The subject (type) of insurance. Policy must have a title.				
627.413(1)(a)	The names of the parties to the contract.				
627.416	Every form shall contain the signature of a company official.				
627.602(1)(c)	Must identify the person who is insured.				
627.602(1)(b)	The time it takes effect and terminates.				
627.413(1)(d)	The time the insurance takes effect and the period it continues. (Effective date/time and the termination date/time.)				
627.413(1)(g)	The form numbers and edition dates of all endorsements attached to the policy, only at time of original issue.				
627.606	The entire contract: List all forms that apply. <i>The policy must contain this provision.</i>				
627.616	Legal action: no legal action within 60 days after written proof of loss given; 5-year statute of limitations 95.11(2)(b). <i>The policy must contain this provision.</i>				
69O-156.014(1)(b)	Change of benefit riders or endorsements to be signed by insured and premium charge to be in policy.				
627.617	Change of beneficiary: Unless irrevocable. <i>The policy must contain this provision.</i>				
627.607	The time limit on certain defenses: 2-year maximum. <i>The policy must contain this provision.</i>				
627.620	Misstatement of age or sex. <i>The policy may contain this provision.</i>				
627.627	Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes. <i>The policy must contain this provision.</i>				
	<b>RATES AND PREMIUMS</b>				
627.413(1)(e)	The premium (May be located on the application or schedule of benefits, if application/schedule is made part of the policy.)				
69O-156.014(1)(f)	A 45 day notice of rate change.				
	<b>BENEFITS</b>				
627.602(1)(a)	The monetary and other consideration to be expressed therein.				

STATUTE/RULE	FILING COMPLIANCE	YES	NO	N/A	PAGE #
627.413(1)(c)	The risk insured against. (Benefits)				
	<b>PAYMENT OF BENEFITS / CLAIMS</b>				
627.413(1)(f)	The conditions pertaining to the insurance. Qualification of the benefits.				
627.610	Notice of claims: Minimum of 20 days or as soon as reasonably possible. <i>The policy must contain this provision.</i>				
627.611	Claim Forms: Company must provide within 15 days. <i>The policy must contain this provision.</i>				
627.612	Proof of loss: Minimum of 90 days or as soon as reasonably possible within 1 year. <i>The policy must contain this provision.</i>				
627.613	Time of payment of claims: Company must pay or deny within 45 days. <i>The policy must contain this provision.</i>				
627.614	Payment of claims: Maximum of \$3,000 to person who cannot execute a valid release. <i>The policy must contain this provision.</i>				
627.6141	Denial of claims – response must not exceed fifteen (15) business days. <i>The policy must contain this provision.</i>				
627.615	Physical examinations: At company’s expense. <i>The policy must contain this provision.</i>				
690-156.005(3)	Policy Provision: No duplication of Medicare benefits.				
690-156.014(1)(c)	Shall not provide for the payment of benefits based in standards described as "usual/reasonable" or "customary" language.				
627.603	Optional death benefits: A health policy may include a provision for paying a death benefit from any cause not to exceed \$1,000; no limit for accidental death.				
	<b>LIMITATIONS AND EXCLUSIONS</b>				
627.602(1)(e)	Requires listing of exceptions and reductions. Must be clearly stated and not ambiguous.				
690-156.005(1)	Limitations or exclusions may not be more restrictive than used by Medicare.				
	<b>PRE-EXISTING CONDITIONS</b>				
690-156.005(2)	Prohibition on excluding or limiting or reducing coverage for named or physical or pre-existing conditions.				
690-156.014(1)(d)	Pre-existing condition limitation must be in a separate paragraph.				
690-156.019	Prohibition against Preexisting Conditions, Waiting Periods, Elimination Periods, & Probationary periods in Replacement Policies or Certificates.				

STATUTE/RULE	FILING COMPLIANCE	YES	NO	N/A	PAGE #
	<b>CANCELLATION / REINSTATEMENT / CONTINUATION</b>				
627.6741(2)	An insurer shall only cancel for nonpayment of premium or material misrepresentation				
627.6741(3)	For group Medicare supplement policies: Conversion right				
627.6741(4)	Cancellation; return promptly unearned portion of any premium paid				
627.608	Grace Period. <i>The policy must contain this provision.</i>				
627.609	Reinstatement. <i>The policy must contain this provision.</i>				
	<b>DEFINITIONS</b>				
627.672 69O-156.003(13)	<b>Definitions: Medicare Supplement Policy</b> - <i>If a term is used in the contract, it must be defined as no more restrictive than these definitions.</i>				
69O-156.003(16)	<b>Required Policy Definitions and Terms: Pre-existing Condition</b>				
69O-156.004(1)	<b>Required Policy Definitions and Terms: (1) Accident, (2) Benefit Period, (3) Convalescent Home, (4) Health Care Expenses, (5) Hospital, (6) Medicare, (7) Medicare Eligible Expense, (8) Physician, (9) Sickness</b> <i>If a term is used in the contract, it must be defined as no more restrictive than these definitions.</i>				
	<b>BENEFIT STANDARDS</b>				
69O-156.006	<b>Minimum Benefit Standards for Pre-Standardized Medicare Supplement policies or certificates issued for delivery prior to 1/1/92.</b>				
69O-156.007(1)(a)-(h)	<b>Benefit standards for 1990 Medicare Supplement policies or certificates issued or delivered on or after 1/1/92 and prior to 6/1/2010.</b>				
69O-156.007(2)(a)-(e)	<b>Standards for Basic (Core) benefits. Plans A-J.</b>				
69O-156.007(3)(a)-(j)	<b>Standards for additional benefits. Plans B-J.</b>				
69O-156.007(4)(a)-(b)	<b>Standard for Plans K and L</b>				
69O-156.0075(1)(a)-(g)	<b>Benefit standards for 2010 Medicare Supplement policies or certificates issued or delivered on or after 6/1/2010.</b>				
69O-156.0075(2)(a)-(f)	<b>Standards for Basic (Core) benefits. Plans A, B, C, D, F, High F, G, M, &amp; N.</b>				
69O-156.0075(3)(a)-(f)	<b>Standards for additional benefits. Plans B, C, D, F, High F, G, M, &amp; N.</b>				
69O-156.008	<b>Standard Medicare Supplement benefit plans for 1990 policies or certificates issued or delivered on or after 1/1/92 and prior to 6/1/2010.</b>				

STATUTE/RULE	FILING COMPLIANCE	YES	NO	N/A	PAGE #
690-156.0085	Standard Medicare Supplement benefit plans for 2010 standardized Medicare supplement benefit policies or certificates issued for delivery with an effective date on or after 6/1/2010.				
	<b>MEDICARE SELECT</b>				
690-156.030	Standards for Medicare Select Policies & Certificates.				
	<b>OPEN ENROLLMENT / GUARANTEE ISSUE</b>				
690-156.009	Open Enrollment				
690-156.0095	Guarantee Issue for Eligible Persons.				
627.6741(1) 690-156.012(3)(b)4	Those insureds who are disabled or have End Stage Renal Disease must be included in the contract.				

**Additional Notes:**

Please upload all documents with document titles that accurately reflect their contents including specific form numbers in the Forms To Be Reviewed section of the Universal Standard Data Letter (UDL).