

**WAVIER OF MINIMUM LIQUID RESERVE REQUIREMENT**

(Debt Service Portion ONLY-651.035(1), Florida Statutes)

**STATE OF FLORIDA**

**OFFICE OF INSURANCE REGULATION**

For the period beginning \_\_\_\_\_, 20\_\_\_\_, and ending \_\_\_\_\_, 20\_\_\_\_.

**A MULTI-FACILITY PROVIDER MUST COMPLETE AND SUBMIT A SEPARATE FORM AND ALL SUPPORTING SCHEDULES THEREUNDER FOR EACH FACILITY FOR WHICH IT IS THE PROVIDER.**

**NOTE - THIS FORM AND ALL SUPPORTING DOCUMENTS ARE REQUIRED TO BE FILED EACH YEAR 60 DAYS BEFORE COMMENCEMENT OF THE PROVIDER'S FISCAL YEAR; OR, 60 DAYS PRIOR TO THE OFFICIAL OPENING DATE OF THE FACILITY IN THIS STATE AND THEREAFTER, 60 DAYS BEFORE THE COMMENCEMENT OF THE PROVIDER'S FISCAL YEAR. "OFFICIAL OPENING DATE" MEANS THE DATE THE FIRST RESIDENT TAKES POSSESSION OF A UNIT.**

**Complete the following for each facility:**

1. Facility file number: \_\_\_\_\_

2. Name and address of "Facility": \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Name and address of "Provider": \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Provider's Federal ID Number: \_\_\_\_\_

5. Provider's fiscal year ends: \_\_\_\_\_

6. This facility was first licensed with the Office of Insurance Regulation pursuant to the provisions of Chapter 651, Florida Statutes, on: \_\_\_\_\_, 20\_\_\_\_.

7. Name, address, title and telephone number of the contact person regarding this form:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FURNISH THE FOLLOWING INFORMATION:**

8. Copy of Trust Indenture.
9. Copy of First Mortgage to residents or trust.
10. Copy of the most recent Audited Financial Statements for the Trust.
11. Provide name and address of Trustee.  

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12. Written confirmation from the escrow agent which states the balance in the escrow account(s) used to meet all outstanding debts of the facility and equipment.
13. A schedule of all outstanding debts on the facility and equipment.
14. Evidence or documentation that the trust is owned entirely (100%) by the residents of the facility.
15. A statement from the provider that upon release, the escrowed funds will be used to satisfy all outstanding debts on the facility and equipment.

**SIGNATURE**

**DIRECTIONS FOR SIGNING THIS REPORT:**

- I. Regardless of the form of the organization, this report **must** be signed by the Facility Administrator or Executive Director **and** one of the following:
  - A. If you are an individual, the report must be signed by you.
  - B. If the organization is a corporation, the report must be signed by one of its corporate officers.
  - C. If the organization is a partnership or unincorporated association, the report must be signed by the managing general partner.
  - D. If the organization is a trust, the report must be signed by all trustees and officers.

**NOTICE!**

- II. Submit a separate signature sheet for each person. The acceptable form is as follows:

I \_\_\_\_\_, of \_\_\_\_\_, an insurer licensed to transact business in the state of Florida, am familiar with the laws of Florida relating to continuing care contracts and do hereby certify under penalty of filing false or misleading documents pursuant to 624.3101, Florida Statutes, or perjury pursuant to 837.06 Florida Statutes, that the information reported above is a full and true reporting of the requested information. This report is submitted for compliance with Chapter 651, Florida Statutes.

Signed Before Me	_____	(Typed Name)
This ____ day of _____, 20____.	_____	(Signature)
NOTARY PUBLIC	_____	(Title)

Personally known \_\_\_\_\_,  
or produced identification

Type of identification produced

(Seal)