Report of Gross Annual Premiums and Enrollment Data for Health Coverages Issued to Florida Residents
Annual Data Filing Instructions

Due on or before March 1 for the Calendar Year Proceeding
(Data Reporting Form OIR-B2-1094 for Calendar Year ____)

Section One: CARRIER and CONTACT ID DEFINITIONS and/or INSTRUCTIONS

The **Company Name** is to be entered as it appears on the carrier's Certificate of Authority issued by the Office of Insurance Regulation.

The **FEIN** is the Federal Employer Identification Number issued to the submitting carrier by the federal government.

The **NAIC Company Code** is the five-digit company code issued to the submitting carrier by the National Association of Insurance Commissioners for identification purposes.

The **Contact Person** is the name and title of the person completing (or overseeing the completion of) this data filing. This is to be the person with whom the Office of Insurance Regulation may correspond if there are any questions concerning the submission of or data contained therein of this data filing.

The **Address** requested is the mailing address of the contact person; that is, the person completing (or overseeing the completion of) this data filing.

The **Phone Number**, **Fax Number** and **Email Address** are that of the contact person; that is, the person completing (or overseeing the completion of) this data filing.

The **Date Filed** is the date that carrier forwards the completed data filing to the Office of Insurance Regulation. The receipt date will be recorded by the Bureau of Life and Health Forms and Rates and reflect the date the submission is received in that Bureau.

Section Two: COLUMN HEADER SPECIFIC DEFINITIONS and/or INSTRUCTIONS

As defined in Section 627.6482(12), **premium** means the entire cost of an insurance plan, including the administrative fee, the risk assumption charge, and, in the instance of a minimum premium plan or stop-loss coverage, the incurred claims whether or not such claims are paid directly by the insurer.

DIRECT PREMIUMS EARNED FOR NEW AND RENEWAL BUSINESS (A)
Requested data is your company's direct premium earned from January 01, through December 31, , inclusive. Provide only premium specific to covered Florida residents.

DIRECT LOSSES INCURRED (B)
Requested data is your company's direct losses incurred from January 01, through December 31, , inclusive. Provide only losses specific to covered Florida residents.

DIRECT PREMIUMS EARNED FOR NEW BUSINESS ONLY (C)
Requested data is your company's direct premium earned for new business only from January 01, through December 31, , inclusive. Provide premium specific to covered Florida residents.

EMPLOYERS, IF GROUP COVERAGE, AT END OF REPORTING CY (D)
For all group categories, provide the number of employers who covered Florida resident employees, as of December 31, .

PRIMARY INSUREDS AT END OF REPORTING CY (E)
Provide the total number of resident individual policyholders or resident group employee/member certificateholders, as of December 31, .

COVERED DEPENDENTS AT END OF REPORTING CY (F)
Provide the total number of individuals who are covered by the primary insured's plan and who receive coverage due to his/her dependent relationship to the primary insured, as of December 31, .

Section Three: LINE SPECIFIC DEFINITIONS and/or INSTRUCTIONS

Major medical coverage means insurance that is designed to cover expenses of serious illness, chronic care (excluding long-term care) and/or hospitalization. The term does **NOT** include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, prepaid products, Medicare supplement, long-term care, or disability income insurance; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which do not duplicate coverage under an underlying health plan and are specifically designed to fill gaps in the underlying health plan, coinsurance, or deductibles; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance. *Please note that short-term major medical coverages are to be reported on Line 20.*

Line 1 GUARANTEE ISSUE ("HIPAA") refers to individual coverage issued on a guarantee basis in accordance with Section 627.6487, F.S.

Line 2 INDIVIDUALLY UNDERWRITTEN means coverage offered after an analysis of an individual's medical conditions is considered.

Line 3 CONVERSION refers to coverages offered on a guarantee issue basis to certificateholders or subscribers leaving a group health insurance program in accordance with Sections 627.6675 and 641.3921, F.S.

Line 4 SELF-EMPLOYED OR SOLE PROPRIETOR refers to a health benefit plan that provides coverage to a self-employed person or sole proprietor in this state, offered on a guaranteed-issue basis pursuant to Section 627.6699, F.S.

Line 5 2 - 50 MEMBER GROUPS applies to a health benefit plan that provides coverage to a small employer of 2-50 persons, which is not marketed directly to the individual employee in accordance with Section 627.6699, F.S.

Line 6 51+ MEMBER GROUPS applies to a health benefit plan that provides coverage to employers of 51 or more persons, which is not marketed directly to the individual employee.

Line 7 GUARANTEE ISSUE See line 1 above.

Line 8 INDIVIDUALLY UNDERWRITTEN Out-of-state group individually underwritten coverages include coverages offered through a trust, association or other mechanism where the individual applicant is subject to medical underwriting in determining the coverage or the rate to be charged.

Line 9 SELF-EMPLOYED OR SOLE PROPRIETOR See Line 4 above.

Line 10 2 - 50 MEMBER GROUPS: See Line 5 above.

Line 11 51+ MEMBER GROUPS: See Line 6 above.

Line 12 ADMINISTRATIVE SERVICES ONLY (ASO): ASO describes the contractual arrangement utilized by a self-funded employer, whereby a separate company processes claims and other administrative needs pertinent to the employer's health care plans.

Line 13 EXCESS / STOP LOSS: As defined in Section 627.6482 (14), F.S., "Stop-loss coverage" means an arrangement whereby a self-insurance plan insures against the risk that any one claim will exceed a specific dollar amount or that an entire self-insurance plan's losses will exceed a specific amount.

Line 14 ACCIDENT ONLY: Accident Only is a form of insurance against loss by accidental bodily injury to the insured.

Line 15 BLANKET: This a health insurance contract that covers all of a class of persons not individually identified in the contract. Please include any student contracts in this category.

Line 16 HOSPITAL, MEDICAL AND SURGICAL POLICIES - INDEMNITY PLANS: This differs from Hospital, Medical and Surgical Expense products in that this type of coverage pays an agreed upon reimbursement amount, but not necessarily the total cost, of covered hospital, medical or surgical services after services are rendered.

Line 17 LONG & SHORT-TERM DISABILITY / LOSS OF INCOME: This is a form of health insurance that provides periodic payments to replace income, actually or presumptively lost, when the insured is unable to work as a result of sickness or injury.

Line 18 LONG-TERM CARE: Also known as "LTC" insurance, this is financial coverage meant to offset some or all of the costs of necessary long-term care.

Line 19 MEDICARE SUPPLEMENT: This is a coverage type guaranteeing that a health plan will pay a policyholder's coinsurance, deductible and co-payments and will provide additional health plan or non-Medicare coverage for services up to a predefined benefit limit.

Line 20 SHORT-TERM HEALTH: Short-Term Health coverage is limited duration major medical insurance. The policy is generally for one year or less. Do NOT include short-term disability income products on this line.

Line 21 SPECIFIED OR DREAD DISEASE: This is a type of health coverage, usually with a high maximum limit, for all types of medical expenses arising out a diseases named in the insurance contract. Please include your cancer coverages on this line.

Line 22 DENTAL/VISION: This is a health insurance contract covering some of the costs of dental/vision care.

Lines 23 – 28 ALL OTHER: Please itemize, adding additional pages as needed, requested data for product types not listed in lines 1-22. Include a brief description of the additional product type on a separate page if necessary.

Section Four: RECONCILIATION of ANNUAL FINANCIAL STATEMENT and REPORTED DATA

Line 29 "Accident and Health Insurance Premiums, Including Policy, Membership and Other Fees" as reported to the Office of Insurance Regulation in Annual Financial Statement

Line 30 Total of lines 1-28, column (A) above (if different from line 29, attach detailed explanation)