



INDIVIDUAL HEALTH COVERAGE POLICY FORMS ISSUED/RENEWED IN FLORIDA

TO BE FILED ON OR BEFORE APRIL 1 FOR THE PRECEDING CALENDAR YEAR

(Data Reporting for Calendar Year \_\_\_\_\_)

Section A: To be completed by all carriers.

Form fields for Section A: Company Name, Mailing Address, City, Contact Person, Contact Person E-Mail Address, FEIN, State, Phone Number, Toll Free Florida Consumer Information Number, NAIC Co Code, Zip code, Fax Number, Date Filed.

Section B: To be completed by all carriers.

CARRIER INDIVIDUAL ELECTION STATUS

Designation should reflect company's election made per Section 627.6475(5), Florida Statutes.

Table with 2 columns: Election Status (Risk Assuming Carrier, Reinsuring Carrier, Withdrawing from the Market, Not Applicable and/or Not authorized to write health coverage in Florida) and Select Only One (checkbox).

Section C: To be completed by all carriers.

INDIVIDUAL HMO SERVICES, MAJOR MEDICAL and HOSPITAL, MEDICAL AND SURGICAL EXPENSE PRODUCT AVAILABILITY

Florida law defines "individual health insurance" as health insurance offered to an individual. This definition includes certificates of coverage offered to individuals in Florida as part of a group policy issued to an association outside this state. "Major medical" 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 short-term limited duration insurance, 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 cannot 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.

Table with 3 columns: Question (In accordance with the statement of Florida law above, does your company currently have individual major medical and/or hospital, surgical, medical expense products issued and/or inforce?) and Yes/No (checkbox).

If YES, please continue to Section D.
If NO, please complete Sections A, B, and C and return this form to the Office



**Section D: To be completed by carriers responding YES to Section C.**

**INDIVIDUAL HMO SERVICES, MAJOR MEDICAL and HOSPITAL, MEDICAL AND SURGICAL EXPENSE PRODUCT DATA**

List plan name and corresponding form number(s) of each individual major medical and/or hospital, surgical, medical expense policy issued and/or inforce with your company. (Additional pages may be added as needed.)	Plan Name	Form Number(s)
Briefly describe the benefits provided by each individual major medical and/or hospital, surgical, medical expense policy issued and/or inforce with your company. Please identify your descriptions using the form number you provided above. (Additional pages may be added as needed.)		
What is the total number of primary insureds covered under the individual major medical and/or hospital, surgical, medical expense policies issued and/or inforce with your company? How many dependents of these primary insured are also covered by these policies? For both, please use the total at the end of the reporting calendar year.	Primary insured	Dependents
What is the total direct premium earned for the reporting calendar year for the individual major medical and/or hospital, surgical, medical expense policies issued and/or inforce with your company?		
Is your company actively marketing individual major medical and/or hospital, surgical, medical expense products?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p><b>If YES, please continue to Section E.</b></p> <p><b>If NO, please complete Sections A, B, C, and D and return this form to the Office</b></p>		

**Section E: To be completed by carriers responding YES to Section D.**

**ACTIVELY MARKETED INDIVIDUAL HMO SERVICES, MAJOR MEDICAL and HOSPITAL, MEDICAL AND SURGICAL EXPENSE PRODUCT DATA**

Identify the two ACTIVELY MARKETED individual major medical and/or hospital, medical and surgical expense policy forms which generate the largest and next to largest direct premium earned volume for your company. If either of these forms is made available with copayment options, riders, endorsements, etc., please specify the most popular option combination based on direct premiums earned volume. Please note: the top two forms identified may consist of any combination of basic policy form and/or policy form combination based on direct premium earned volume.	Plan Name	Largest Volume Producing Product	Second Largest Volume Producing Product
	Form Number(s)		



**Section E:** To be completed by carriers responding YES to Section D. *(continued)*

**ACTIVELY MARKETED INDIVIDUAL HMO SERVICES, MAJOR MEDICAL and HOSPITAL, MEDICAL AND SURGICAL EXPENSE PRODUCT DATA**

		Largest Volume Producing Product	Second Largest Volume Producing Product
For the two products identified above, please provide the date this Office approved each form, if applicable.			
For the two products identified above, provide the Office's file log number under which each form was approved, if applicable			
Briefly describe the benefits provided by the two products identified above. (Additional pages may be added as needed.)			
What is the number of primary insureds (exclusive of coverage issued to HIPAA-eligibles) covered under the two products identified above? How many dependents of these primary insured are also covered by these policies? What is the number of HIPAA-eligibles covered under the two products identified above? For all three, please use the total at the end of the reporting calendar year.	Primary insured		
	Dependents		
	HIPAA-eligibles		
What is the total direct premium earned for the reporting calendar year for the two products identified above?			
For the two policy forms identified above: <ul style="list-style-type: none"> <li>· Please attach a copy of each form (and any options, riders, endorsement, etc.)</li> <li>· Attach all marketing materials to be provided to eligible individuals (HIPAA-eligible).</li> <li>· Explain how these eligible individuals are to be informed of the availability of your company's applicable individual coverages.</li> </ul> (Additional pages may be added as needed.)			

**Section F:** To be completed by Health Maintenance Organization Only

**INDIVIDUAL HMO SERVICES, MAJOR MEDICAL and HOSPITAL, MEDICAL AND SURGICAL EXPENSE PRODUCT SERVICE AREAS**

Please attach a listing of the service areas (by county, zipcode, metropolitan area, etc.) approved on your company's Health Care Provider Certificate and which individual product types are marketed in these areas. (Additional pages may be added as needed.)