REQUEST FOR WAIVER
Pursuant to Rule 4-193.055 Florida Administrative Code (FAC)

_____
(Date)

File No.: _____

Facility Name: _____

Provider Name: _____

Pursuant to Rule 4-193.055, FAC, request is made for a waiver of the following:

1. ☐ **Quarterly Report for the period ending _____, 20____.**

2. ☐ **Tri-annual Examination for the period ended _____ , 20____.**

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 (FS), or perjury pursuant to 837.06, FS, that the information reported herein is a full and true reporting of the requested information.

I certify and represent to the Office of Insurance Regulation (the Office) that we are accredited by the Continuing Care Accreditation Commission in good standing and that none of the conditions contained in Rule 4-193.055(1)(b) or (2)(a thru f), FAC, exist.

Further, we understand this request for waiver is valid only for the period and purpose specified above and nothing herein contained restricts the Office's authority to conduct investigations or examinations, request information or otherwise enforce the provisions of Chapter 651, FS.

_____	_____
(Typed Name and Title)	(Typed Name and Title)
_____	_____
(Signature)	(Signature)

NOTE: Attach a copy of the current accreditation certificate and current evidence of good standing, from the Continuing Care Accreditation Commission. Please file this form as early as possible. Denial of this waiver will not be considered a mitigating factor in regards to reports filed late.

FOR BUREAU USE ONLY

Examiner: _____ **Supervisor:** _____

FILE NO. _____

INTERROGATORIES

FOR THE PERIOD ENDED _____, 20_____

Contact person for this report _____

Phone number __ _____

Indicate a "Yes" or "No" answer to the following questions. If an answer of "Yes " is given, attach supporting documentation to this report.

1. Has there been any change in the information originally filed under 651.022(2), FS?

   Yes or No (please circle)

2. Have any judgements or fines been filed against the provider?

   Yes or No (please circle)

3. With respect to any business operations of the provider, have any bankruptcy, delinquency, receivership, foreclosure or loan default proceedings been initiated during this period?

   Yes or No (please circle)

4. Have there been any administrative actions or convictions (other than minor traffic violations) against any officer, director, or controlling person of the provider (including the executive director or administrator), it's affiliates, or the management company?

   Yes or No (please circle)

5. Have there been any changes in the officers, directors, shareholders, or management of the provider, or of any management company managing a facility for a provider?

   Yes or No (please circle)

6. Are any bills due during the period, unpaid (including provider and facility tax and debt payments)? For this question, due is defined as the date the creditor expects payment.

   Yes or No (please circle)

7. As of the end of this reporting period, has there been any new financing, additional financing or refinancing?

   Yes or No (please circle)