Florida Office of Insurance Regulation

REQUEST FOR WITHDRAWAL FROM MINIMUM LIQUID RESERVES

FLORIDA COMPANY CODE:

FLORIDA PROVIDER GROUP CODE:

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

REQUEST FOR WITHDRAWAL FROM MINIMUM LIQUID RESERVES
FILED BY

____
(Continuing Care Provider)

FOR

____
(Continuing Care Facility)

TO THE
FLORIDA OFFICE OF INSURANCE REGULATION

Life & Health Financial Oversight
200 East Gaines Street Tallahassee, FL 32399 - 0331

GENERAL INSTRUCTIONS

1. Provider may request approval from the Florida Office of Insurance Regulation (“Office”) to withdraw funds from its minimum liquid reserves pursuant to Section 651.035, Florida Statutes; subsection (6) applies to withdrawals from the renewal and replacement reserve and subsection (7)(b) applies to all other withdrawals.

2. To request approval to withdrawal minimum liquid reserve funds, please complete this form and submit the requested supporting documentation. Complete Section I to request a withdrawal from the renewal and replacement reserve pursuant to Section 651.035(6), Florida Statutes, or Section II for any other request to make a withdrawal from the minimum liquid reserves pursuant to Section 651.035(7)(b), Florida Statutes.

3. Submit this form and supporting documentation electronically via the Office’s system at https://www.floir.com/iportal.

4. The Office will approve requests for withdrawal from the renewal and replacement reserve that comply with Section 651.035(6), Florida Statutes. In reviewing requests for other withdrawals pursuant to Section 651.035(7)(b), Florida Statutes, the Office may disapprove any request to withdraw funds if it determines that the withdrawal is not in the best interest of the residents.

5. Note that pursuant to Section 651.035(7)(a), Florida Statutes, a provider may withdraw funds held in escrow without the approval of the Office if the amount held in escrow exceeds the requirements of this section and if the withdrawal will not affect compliance with Section 651.035, Florida Statutes.

6. The Provider’s MLR funding year is the 12-month period beginning 61 days after a Provider’s Annual Report Filing and Minimum Liquid Reserve Calculation are due to be filed. For example, for a Provider with a fiscal year ending on December 31, the MLR funding year begins July 1 of the subsequent year.

7. Attestation. After completing this form, at least two individuals must attest to the filing, as explained on the Attestation. Signatures affixed to the Attestation must be under seal of a notary public. After the Attestation(s) are physically signed and notarized, upload PDFs of them into filing. Please review the Attestation(s) to ensure that the name of the notary public, commission number, commission expiration date, and any required seal or stamp are visible on the form before submitting the filing.

ATTESTATION

This filing will not be considered complete unless it has been attested to by the Executive Director or Facility Administrator and, depending on the Provider's business structure, at least one other individual as set forth below.

- If the Provider is an individual, the report must be attested to by that individual.
- If the Provider is a corporation or a limited liability company, the report must be attested to by one of its corporate officers.
- If the Provider is a partnership or unincorporated association, the report must be attested to by the managing general partner.
- If the Provider is a trust, the report must be attested to by all trustees and officers. Please print additional copies of this page as necessary to provide all required attestations.

The undersigned state that they are representatives of the Provider as specified above and that they are familiar with the laws of Florida relating to continuing care contracts. The undersigned acknowledge that this report is submitted for compliance with Chapter 651, Florida Statutes, and certify under penalty of filing false or misleading documents pursuant to Sections 817.2341 and 837.06, Florida Statutes, that the information provided herein is a full and true reporting of the requested information. The undersigned represent that they are authorized to file this report on behalf of the Provider and that by affixing their signatures to this document, the Provider has executed this instrument.

__________________________________ __________________________________
(Signature) (Title)

__________________________________ __________________________________
(Typed Name) (Date)

State of ______________
County of ____________

The foregoing was sworn to and subscribed before me this _____ day of _______________, 20_____, by

____, who is personally known to me or who has produced
(Name of Affiant)
_______________________________ as identification.

(Notary Stamp) ____
(Signature of the Notary and Date Commission Expires)

__________________________________ __________________________________
(Signature) (Title)

__________________________________ __________________________________
(Typed Name) (Date)

State of ______________
County of ____________

The foregoing was sworn to and subscribed before me this _____ day of _______________, 20_____, by

____, who is personally known to me or who has produced
(Name of Affiant)
_______________________________ as identification.

(Notary Stamp) ____
(Signature of the Notary and Date Commission Expires)

FILING CONTACT

Name: ____

Position/Title ____

Address: ____

City: _________________________________ State:_______________

Zip: ________________________

Phone: ____

Ext: _________________________

Email: ____

I. Request for Withdrawal from the Renewal and Replacement Reserve

Each fiscal year, a Provider may withdraw up to 33 percent of the total renewal and replacement reserve available. The reserve available is equal to the market value of the invested reserves at the end of the Provider's prior fiscal year. The withdrawal must be used for capital items or major repairs. Before any funds are eligible for withdrawal, the Provider must obtain written permission from the Office.

1. Calculate the maximum allowable withdrawal amount.

A. Provide the following information if the Provider has no outstanding withdrawal balance and its renewal and replacement reserve was fully funded as of the end of the Provider's prior fiscal year. If the Provider has an outstanding withdrawal balance, do not complete A., and complete B., instead.

(1) Provide the total renewal and replacement reserve requirement from Schedule III of the Minimum Liquid Reserve Calculation, Form OIR-A3-477, for the Provider's current MLR funding year: _______________________

(2) Calculate the maximum withdrawal allowable by multiplying the amount in 1.A(1) above by .33: _______________________

(3) Provide the amount of the requested withdrawal, which cannot exceed the amount calculated in 1.A.(2) above: ________________

B. Provide the following information if the Provider has an outstanding withdrawal balance that was not fully repaid as of the Provider's prior fiscal year.

(1) Provide the total renewal and replacement reserve requirement from Schedule III of the Minimum Liquid Reserve Calculation, Form OIR-A3-477, for the Provider's current MLR funding year: _______________________

(2) Provide the following information regarding all previous withdrawals from and repayment of the renewal and replacement reserve with an outstanding balance as of the last fiscal year-end.

	(A) Last Withdrawal	(B) Previous Withdrawal 1	(C) Previous Withdrawal 2	(D) Previous Withdrawal 3	(E) Total Balance Outstanding (A+B+C+D)
Withdrawal amount					
Monthly repayment amount					
Date of 1st repayment					
Date of final scheduled repayment					
Sum of repayments made as of the most recent fiscal year-end					
Balance outstanding as of most recent fiscal year-end					

(3) Calculate the total available balance by subtracting the amount reported in 2.(E) from the amount reported in 2.B.(1): ____________________

(4) Calculate the maximum withdrawal allowable by multiplying the amount in (3) above by .33: ____________________

(5) Provide the amount of the requested withdrawal, which cannot exceed the amount calculated in 1.B.(4) above: _________________

2. Provide an anticipated payment schedule.

Within 30 days after the withdrawal of funds, the Provider must begin refunding the reserve account in equal monthly payments that allow for a complete funding of the withdrawal within 36 months. If the Provider fails to make a required monthly payment or the payment is late, the provider must notify the office within 5 days after the due date of the payment and file an updated repayment schedule. No additional withdrawals from the renewal and replacement reserve will be allowed until all scheduled payments are current.

A. Calculate the minimum payment amount by dividing the amount of the requested withdrawal from 1.A.(3) or 1.B.(5), as applicable, by 36: _________________

B. Proposed monthly repayment amount cannot be less than the amount calculated in 2.A. above. Monthly payments should be equal in amount, pursuant to Section 651.035(6)(b), Florida Statutes: __________________

C. Provide the anticipated date of the proposed monthly repayment amount, which cannot be less than the amount calculated in 2.A. above. Provide the anticipated date of the first payment amount which must be within 30 days of the withdrawal, pursuant to Section 651.035(6)(b), Florida Statutes: ____________________

D. Provide the anticipated date of last payment, which may be no later than 36 months after the initial payment: ____________________

3. Upload to this filing a detailed explanation of the intended use of the proceeds of the renewal and replacement reserve withdrawal. The funds withdrawn may only be used for capital items and major repairs.

4. Upload to this filing current escrow statements demonstrating that the provider is in compliance with the minimum liquid reserve funding requirements for the current MLR funding year.

5. Complete the sworn affidavit attached to this form as Exhibit A and upload it to this filing. After completing the affidavit, print, sign, and notarize it. After the affidavit has been physically signed and notarized, upload a PDF copy into the filing as a Miscellaneous Document titled “Affidavit.” This component requires physical signatures from the attesting individuals and the notary. Please review to ensure that the name of the Notary Public, Commission Number, Commission Expiration Date, and any required seal or stamp are visible on the form before submitting the filing.

6. Provide a board resolution indicating board approval of the withdrawal and use of funds as described in this filing. The board resolution should be uploaded into the filing as a Miscellaneous Document titled “Board Resolution.”

Requests for Other Withdrawals from the Minimum Liquid Reserves

1. Please provide the amount of the requested withdrawal: ____________________

2. Please indicate which minimum liquid reserve(s) the Provider is requesting to make a withdrawal from.
   - o Debt service reserve
   - o Operating reserve
   - o Renewal and replacement reserve

3. Please provide the name of the escrow agent and the account numbers for the escrow accounts from which the Provider is requesting to withdraw funds or indicate if the funds are on deposit with the Department of Financial Services Bureau of Collateral Management. ____
   ____

4. What is the intended use of the funds for the requested withdrawal?
   ____
   ____
   ____
   ____

5. What is the Provider's plan to fund the repayment of the requested minimum liquid reserve withdrawal?
   ____
   ____
   ____
   ____

6. Please upload an anticipated repayment schedule to allow for a complete funding of the requested withdrawal. The repayment schedule should be appropriately labeled and uploaded as a Miscellaneous Document into this filing. The payment schedule must include the following:
   - A. The accounts into which the payments will be deposited;
   - B. The number of payments;
   - C. The anticipated dates of all payments; and
   - D. The amount of payments.

7. Please upload documentation evidencing why the withdraw is necessary for the continued operation of the facility. Documentation should be appropriately labeled and uploaded as a Miscellaneous Document into this filing.

8. Complete the sworn affidavit attached to this form as Exhibit B and upload it to this filing. After completing the affidavit, print, sign, and notarize it. After the affidavit has been physically signed and notarized, upload a PDF copy into the filing as a Miscellaneous Document titled "Affidavit." This component requires physical signatures from the attesting individuals and the notary. Please review to ensure that the name of the Notary Public, Commission Number, Commission Expiration Date, and any required seal or stamp are visible on the form before submitting the filing.

9. Provide a board resolution indicating board approval of the withdrawal request and use of funds as described in this filing. The resolution should include an acknowledgment that if the withdrawal is approved by the Office, the Provider will be impaired pursuant to Chapter 651, Florida Statutes. The board resolution should be uploaded into the filing as a Miscellaneous Document titled "Board Resolution."

EXHIBIT A – AFFIDAVIT

Two officers or general partners of the Provider must complete the following.

I, ____, and I, ____, representing ______________________ , a continuing care Provider licensed to transact business in the state of Florida, after being duly sworn, do depose and certify under penalty of perjury that the intended use of funds for this withdrawal from the renewal and replacement reserve is fully disclosed in this filing and this withdrawal request has been duly authorized and approved by the board of directors of the Provider or a similarly authorized controlling body if the Provider is not organized as a corporation.

Officer/Partner 1:

____
(Signature)

____
(Name)

____
(Title)

____
(Date)

State of ________________

County of _______________

The foregoing instrument was acknowledged before me this _________ day of _________________, _________, by ______________________________ as ____ for ____.

____
(Signature of Notary)

____
(Print, Type, or Stamp Name of Commissioned Notary)

Personally Known __ or Produced Identification __
Type of Identification Produced

____

My Commission Expires

____

Officer/Partner 2:

____
(Signature)

____
(Name)

____
(Title)

____
(Date)

State of ________________

County of _______________

The foregoing instrument was acknowledged before me this _________ day of _________________, _________, by ______________________________ as ____ for ____.

____
(Signature of Notary)

____
(Print, Type, or Stamp Name of Commissioned Notary)

Personally Known __ or Produced Identification __
Type of Identification Produced

____

My Commission Expires

____

EXHIBIT B – AFFIDAVIT

Two officers or general partners of the Provider must complete the following.

I, ______________________________________, and I, ____, representing _____________________ , a continuing care Provider licensed to transact business in the state of Florida, after being duly sworn, do depose and certify under penalty of perjury that this filing fully discloses the amount, intended use of funds, and reasons why the withdrawal is necessary for the continued operation of the facility and that this withdrawal request has been duly authorized and approved by the board of directors of the Provider or a similarly authorized controlling body if the Provider is not organized as a corporation. We acknowledge that this withdrawal, if approved, will cause the Provider to be impaired pursuant to Chapter 651, Florida Statutes.

Officer/Partner 1:

____
(Signature)

____
(Name)

____
(Title)

____
(Date)

State of ______________

County of ______________

The foregoing instrument was acknowledged before me this ________ day of ________________, ________, by ___________________________ as ____________________________________ for _______________________________________.

____
(Signature of Notary)

____
(Print, Type, or Stamp Name of Commissioned Notary)

Personally Known __ or Produced Identification __

Type of Identification Produced

____

My Commission Expires

____

Officer/Partner 2:

____
(Signature)

____
(Name)

____
(Title)

____
(Date)

State of ______________

County of ______________

The foregoing instrument was acknowledged before me this ________ day of ________________, ________, by ___________________________ as ____________________________________ for _______________________________________.

____
(Signature of Notary)

____
(Print, Type, or Stamp Name of Commissioned Notary)

Personally Known __ or Produced Identification __

Type of Identification Produced

____

My Commission Expires

____