Office of Insurance Regulation
Specialty Product Administration

FLORIDA COMPANY CODE:
6 5 ___ ___ ___

FEDERAL EMPLOYER IDENTIFICATION NUMBER:
__ __ **-** __ __ __ __ __ __ __

ANNUAL REPORT FOR MOTOR VEHICLE MANUFACTURERS

_____

(NAME OF THE MOTOR VEHICLE MANUFACTURER)

TO THE

OFFICE OF INSURANCE REGULATION

OF THE

STATE OF FLORIDA

200 East Gaines Street
Tallahassee, FL 32399 - 0331

FOR THE YEAR ENDED

_____**, 2 0** ___ ___

GENERAL INFORMATION AND INSTRUCTIONS

1. This report must be filed electronically through the Regulatory Electronic Filing System (REFS). Paper reports are not accepted as complying with the filing requirement.

2. Either Adobe Reader 7.0.5 or higher, or Adobe Acrobat Standard/Professional 7.0.5 or higher is required to properly complete the filing. Further information is available at the following link:

   http://www.floir.com/pdf/REFS_Adobe_LiveCycle_Instructions_r.pdf

3. A session key was assigned when you downloaded this report. This session key has an expiration date and time. **Any data that is not saved or submitted prior the expiration time will be lost**.

4. Please complete:
   a. The **Invoice**, attach a check for the filing fee of $100, and mail to the address shown on the I**nvoice**. The payment must be received by the Office of Insurance Regulation no later than March 1. A copy of the invoice and check must be attached to this filing.
   b. The **Request for Exemption from Examination** (Form OIR-A3-1985), attach a check for the filing fee of $2,000 and mail to the address shown on the Invoice. The payment must be received by the Office of Insurance Regulation no later than March 1. A copy of the invoice and check must be attached to this filing.

5. Two boxes are shown in the upper right hand corner of each report page. Clicking on the box beside "Highlight Fields" shades all places in which data may be entered. Clicking on the box beside "Highlight Required Fields" shades those areas where data must be entered to submit the form, based on previous entries on the form.

6. Please enter all numeric fields with numbers only. Commas, dashes, dollar signs, are not permitted.

7. Unanswered questions and blank lines on schedules will not be accepted. If no answers or entries are to be made, enter "0" on all lines asking for a numeric response and "None" or "N/A" on all lines requesting a non-numeric response.

8. If additional explanations, supporting statements or schedules are added or are necessary, the additions should be properly cross-referenced to the applicable report item. This additional information should be in electronic format (i.e. Word, Excel, PDF, etc) or, if in paper format, scanned in as a PDF, and should be uploaded and attached to the filing as the appropriate Component Named document or as a Miscellaneous Document. If posted as Miscellaneous Document, be sure to assign a descriptive Name to the document.

9. "Save" and "submit" buttons are provided on the last page of this report. Pressing the "s" key while pressing the "ALT" key will display the last page. Clicking the "Save" button will be save the data to our website, but not to your computer. **It is strongly recommended that you save your data periodically as you fill in this form.** Confirmation messages are sent when data is successfully saved or submitted.

10. Saving or submitting causes data to be verified for completeness, and you will be notified if errors have occurred. Validation errors must be corrected in order to submit the data. Once the data is successfully submitted, changes or **additions must be made by amending the online filing.**

11. Please print, sign, notarize and scan the STATEMENT page (see next page); then upload the PDF version of the signed/notarized page as the **Signed Jurat Page**.

Please see #11 of the Instructions Page.

Company Name: _____
Company FEIN: _____ Florida Company Code: _____ Period Ending Date: _____
State and Date of Incorporation/Organization: (State/Prov): _____ (Date): _____
Date Licensed by the Office of Insurance Regulation: (Date): _____
Date Commenced Business: (Date): _____

Address of Home Office:
Street: _____
City: _____ State/Prov: _____ Zip/Postal Code: _____
Phone: _____ Ext: _____ Fax: _____

Address of Main Administrative Office:
Street: _____
City: _____ State/Prov: _____ Zip/Postal Code: _____
Phone: _____ Ext: _____ Fax: _____

Mailing Address:
Street: _____
City: _____ State/Prov: _____ Zip/Postal Code: _____
Phone: _____ Ext: _____ Fax: _____

Records Location (if different than Main Office):
Street: _____
City: _____ State/Prov: _____ Zip/Postal Code: _____

Address of Principle Florida Office:
Street: _____
City: _____ State/Prov: _____ Zip/Postal Code: _____
Phone: _____ Ext: _____ Fax: _____

Website: _____

Type of entity (check one)
☐ Corporation – For profit ☐ Sole proprietorship
☐ Corporation – Not for profit ☐ Limited liability company
☐ Partnership ☐ Other:

Contact Name: _____
Contact Title: _____
Phone: _____ Ext: _____ Fax: _____
Email Address: _____

OFFICERS / DIRECTORS / MEMBERS
Show full name (initials not acceptable)

Chief Executive Officer _____
President _____
Vice President _____
Secretary _____
Treasurer / Chief Financial Officer _____
Chairman of the Board _____

Directors / Members

STATE OF: _____

COUNTY OF: _____

_____, President, _____, Secretary, and _____, Chief Financial Officer (or corresponding person having charge of the Financial records of the licensee, of the _____ being duly sworn each for himself or herself deposes and says that they are the above-described officers of the said licensee, and that on the reporting period stated above, all of the herein assets were the absolute property of the said licensee, free and clear from any liens or claims thereon, except as herein stated, and that this report, together with related exhibits, schedules and explanations therein contained, annexed or referred to is a full and true statement of all assets and liabilities and of the condition and affairs of the said licensee as of the reporting period stated above, and of its income and deductions for the period reported.

Subscribed and Sworn to before me this

_____ day of _____ , 20 _____ _____ President/Owner

Notary Public: _____ _____ Secretary

Commissioner Number: _____ _____ Treasurer/CFO

Expiration Date: _____

Company Name: Period Ending:

Print this page

EXHIBIT I
Recap of FLORIDA Premium Written for the 12 Months Ending __/__/__

	1-Year or Less Contracts	2-Year Contracts	3-Year Contracts	4-Year Contracts	Others (5-Year or Longer)	Totals
Gross Written Premium Current Year	$	$	$	$	$	$
Less Cancellations and Refunds	( )	( )	( )	( )	( )	( )
Totals	$	$	$	$	$	$

EXHIBIT II
Recap of FLORIDA In-Force Premiums

	Number Of Warranties	Premium Received and Outstanding	Unearned Premium Reserve (UPR)	Amount of Premium Covered By CLP
In-Force end of prior year		$	$	$
Audit adjustments to prior year				
Issued during the year				
Cancelled during the year	( )	( )	( )	( )
Expired during the year	( )	( )	( )	( )
Earned during the year			( )	
In-force end of current year		$	$	$

EXHIBIT III
Reported Claims Incurred - FLORIDA

EXCLUDING ALL IBNR CLAIMS	(1) Reported claims paid In the current year	(2) Total reported claims Unpaid	(3) Reported claims Unpaid at end of previous year	(4) Reported claims incurred current year (1+2-3=4)
Number				
Amount	$	$	$	$

EXHIBIT VI
Claims Exposure - FLORIDA

	(1) Total Claims Paid	(2) Total Claims Covered by CLP	(3) % of Claims Covered by CLP
Florida	$	$	**%**

Company Name: Period Ending:

LIST OF OFFICERS/DIRECTORS AND KEY PERSONNEL

Complete the following for all officers, directors, partners, members, and facility executive director/administrators. Include shareholders and affiliates holding at least 10% interest in the operations of the provider. State the percentage owned. If such person and/or shareholder has been appointed, elected, nominated, designated or has been added to this list during this report period, place a check in the "New" column provided. If required biographical information has not been previously submitted on those checked, please refer to the instructions provided at http://www.floir.com/pdf/OfficeDirector.pdf.

Name	Position/Title	Residence Address	City	State/ Prov.	Zip/Postal Code	Date of Birth	%	New
								☐
								☐
								☐
								☐
								☐
								☐
								☐
								☐
								☐
								☐
								☐
								☐

Company Name: Period Ending:

LIST OF COMPANIES

Complete the following for all companies and affiliates holding at least 10% interest in the operations of the provider. State the percentage owned. If such company has been added to this list during this report period, place a check in the "New" column provided.

Name	Business Address	City	State/ Prov.	Zip/Postal Code	FEIN	%	New
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐

Office of Insurance Regulation
Specialty Product Administration

Licensee: _____

Address: _____

City, State Zip _____

APPLICATION for LICENSE CONTINUANCE

MOTOR VEHICLE SERVICE AGREEMENT COMPANY

For the period: 03/01/20 __ __ to 02/2 __ /20 __ __

Federal Employer ID Number: __ __ - __ __ __ __ __ __ __

FL Company Code: __ __ __ __ __

Due by March 1

IN COMPLIANCE WITH THE LAWS OF FLORIDA, THE ABOVE NAMED DOES HEREBY APPLY FOR RENEWAL OF ITS MOTOR VEHICLE SERVICE AGREEMENT COMPANY LICENSE AUTHORIZING THE AFORESAID TO PERFORM SUCH DUTIES IN THIS STATE PURSUANT TO THE LAWS OF FLORIDA.

_____	_____	_____
President's Name	Signature	Date
_____	_____	_____
Secretary's Name	Signature	Date
_____	_____	_____
Treasurer's Name	Signature	Date

INSTRUCTIONS:

1. If you wish to renew, complete and sign this application, detach it from this report and forward it along with your remittance in the amount of $100.00 made payable to the **Florida Department of Financial Services.**

2. The application and remittance must be sent to:

   Florida Department of Financial Services
   Revenue Processing Section
   Post Office Box 6100
   Tallahassee, Florida 32314-6100

3. The renewal application and remittance must be received on or before March 1.

AMOUNT	TYPE	CLASS	FEE	TR ACCT
$100.00	**10**	**33**	**L**	**3002**

Company Name: Period Ending:

Licensee: _____

_____

Address: _____

_____

City, State Zip _____

APPLICATION for EXEMPTION FROM FIELD EXAMINATION

MOTOR VEHICLE SERVICE AGREEMENT COMPANY or MANUFACTURER

For the period: 03/01/20 __ __ to 02/2 __ /20 __ __

Federal Employer ID Number: __ __ - __ __ __ __ __ __ __

FL Company Code: __ __ __ __ __

Due by March 1

PURSUANT TO SECTION 69O-200.014, FLORDA ADMINISTRATIVE CODE, THE ABOVE NAMED DOES HEREBY APPLY FOR EXEMPTION FROM THE FIELD EXAMINATION REQUIRED BY SECTION 634.141, FLORIDA STATUTES. THE LICENSEE CERTIFIES COMPLIANCE WITH THE REQUIREMENTS OF SECTION 69O-200.014, FLORDA ADMINISTRATIVE CODE.

_____	_____	_____
President's Name	Signature	Date
_____	_____	_____
Secretary's Name	Signature	Date
_____	_____	_____
Treasurer's Name	Signature	Date

INSTRUCTIONS:

1. If you wish to renew, complete and sign this application, detach it from this report and forward it along with your remittance in the amount of $2,000.00 made payable to the **Florida Department of Financial Services.**
2. The application and remittance must be sent to:

   Florida Department of Financial Services
   Revenue Processing Section
   Post Office Box 6100
   Tallahassee, Florida 32314-6100

3. The application for exemption and remittance must be received **on or before March 1**.

AMOUNT	TYPE	CLASS	FEE	TR ACCT
$2,000.00	**10**	**38**	**F**	**3001**

OIR-A3-1984
Pub 01/10
Rule 69O-200.015

Company Name: Period Ending:

INVOICE

ANNUAL REPORT FOR MOTOR VEHICLE MANUFACTURERS
REQUEST FOR PAYMENT OF APPLICATION FEES

NAME OF COMPANY: _____

FEIN# _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

ADDRESS (IF DIFFERENT FROM COMPANY ADDRESS)

_____

_____

(CITY) (STATE) (ZIP CODE)

In reference to the submission by the above-referenced specialty insurer's application to do business in Florida, it is necessary to return this form with the proper payment.

PLEASE NOTE:

1. Send a check in the proper amount made payable to the Department of Financial Services and **mail the check and invoice only** to:

   Department of Financial Services
   Bureau of Financial Services, Receipts Section
   P.O. Box 6100
   Tallahassee, Florida 32314-6100

2. Send a **copy of the check** and a **copy of the invoice** along with the completed application package to:

   Office of Insurance Regulation
   Application Coordination Section
   200 East Gaines Street, Larson Building
   Tallahassee, Florida 32399-0332.

_____

For Accounting Use Only:

BT	TYCL	FT	Fee Amount	Receipt Number
C	1224	F	$100.00	(validated below)

Company Name: Period Ending:

SAVE/SUBMIT PAGE

Save -Use this button to save your data to our server. **It is strongly recommended that you save your data periodically as you fill in this form.** You can still save your data even if you have validation errors appear below.

Submit Final -Use this button if you have entered all the required information and want to submit this data to our server. If you have validation errors, they must be corrected before being able to submit the form data. **Once you successfully submit the form data, you can no longer make changes.**

The session key will expire on: Eastern Time

Save **Submit Final**