OFFICE OF INSURANCE REGULATION
Life & Health Product Review

GENERAL INFORMATION AND SURPLUS STATEMENT FOR SELF-FUNDED HEALTH BENEFIT PLANS

GENERAL INFORMATION

	BENEFIT (A)	BENEFIT (B)	BENEFIT (C)
1. TYPE OF BENEFIT			
2. NUMBER OF COVERED EMPLOYEES			
SINGLE (EMPLOYEE ONLY)			
FAMILY (EMPLOYEE AND DEPENDENTS)			
3. CLAIMS INCURRED			
4. ANNUAL CLAIM COST PER EMPLOYEE (ITEM 3 / ITEM 2)			

SURPLUS STATEMENT

(THIS SCHEDULE TRACES THE DEVELOPMENT OF SURPLUS IN THE PLAN FROM THE PRIOR YEAR TO THE END OF THE CURRENT YEAR.)

1. SURPLUS FROM PRIOR YEAR (IF A DEFICIT, SHOW AS NEGATIVE SURPLUS) _____
2. CHANGE IN SURPLUS FROM FUND OPERATIONS (GAIN OR LOSS FOR YEAR) _____
3. CHANGE IN SURPLUS DUE TO OTHER FACTORS (CONTRIBUTION, WITHDRAWAL) _____
4. OVERALL CHANGE IN SURPLUS, PRESENT YEAR _____
5. SURPLUS, END OF CURRENT YEAR (SUM OF ITEM 1AND ITEM 4) _____

THE SURPLUS FROM THE END OF THE PRIOR YEAR SHOULD AGREE WITH THE STARTING SURPLUS FOR THE CURRENT YEAR. IF THEY DO NOT COINCIDE, PLEASE PROVIDE AN EXPLANATION.

NOTE: IF LINE 5 IS NEGATIVE, THE PLAN IS NOT IN GOOD STANDING WITH THE FLORIDA OFFICE OF INSURANCE REGULATION. THIS DEFICIT MUST BE REMOVED BY AN INFUSION OF AN AMOUNT AT LEAST EQUAL TO THE DEFICIT. IF THE DEFICIT IS TO BE LIQUIDATED OVER A PERIOD OF TIME, PLEASE PROVIDE THE DETAILS OF THIS PROGRAM FOR CONSIDERATION, ALONG WITH A SUPPORTING ACTUARIAL OPINION. IF THE PLAN'S SURPLUS IS LESS THAN SIXTY DAYS OF ANTICIPATED CLAIMS, OTHER QUESTIONS MAY BE ASKED OF THE PLAN AS THE OFFICE SEES FIT.