Florida Office of Insurance Regulation

Calendar Year Life & Health Gross Annual Premiums and Enrollment (GAP) Filing Requirements

Pursuant to Sections 624.316, 624.3161, & 627.9175, Florida Statutes

If you have any questions during your submission process, please contact

Market Research and Technology Unit

Via email: GapReporting@floir.com

The Florida Office of Insurance Regulation (Office) is conducting an examination of the Florida Life, Accident & Health market pursuant to Sections 624.316, 624.3161, & 627.9175, Florida Statutes. This communication is being sent to your company's last GAP filer and the company financial statement contact.

Compliance reports are to be submitted on an individual company basis. Group reports will not be accepted.

Additionally, the following item is required to be included in your company's submission:

· Your company's submission must contain a Notarized Affidavit, signed by a company officer, stating the information provided is true and correct. A downloadable "Word" version is available at http://www.floir.com/siteDocuments/CertificationNotarizedAffidavitGAPDCAM.doc

Please note: Additional underlying documentation shall be available upon request of the Office.

The Insurance Regulation Filing System (IRFS) application located at https://irfs.fldfs.com/ is required to be used to submit your data. A guide to creating a filing in IRFS is located here.

The required data reporting template may be downloaded from within IRFS beginning January 1.

Changes since CY2016 template:

- *Tabs GAP_1386 and GAP_Supplemental have been removed.*
- *Added tab Life_Annuity that collects information on life insurance and annuity business for the calendar year (see detailed instructions). If the company does not have Life & Annuity business, please enter zeroes.*
- *Tab GAP_1094:*
  - *Combined In-State and Out-of_State for Grandfathered and Transitional Major Medical segments.*
  - *Combined lines 17-19 (Accident Only, Accidental Death & Dismemberment, and Blanket Accident/Sickness) from the previous year's template into one Line 9 under Other Accident & Health Coverages.*
  - *Line 23 from last year's template (Hospital Indemnity) has been merged into the Limited Benefit segment on Line 15 under Other Accident & Health Coverages.*
  - *Line 23 now includes as Other: Prepaid Health Services not listed above (including ambulance services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services), Champus/Tricare Supplement, Travel, and Student coverages*
  - *Line 24 now includes HCPP, Medicaid (All Titles), SCHIP, FEHBP, Florida Healthy Kids, Florida Health Flex Plans, self-insured business.* ***Do Not Include:*** *credit (group and individual), or credit A&H (group and individual)*

Required Filers and General Reporting Definitions

Section 624.316, F.S., authorizes the Office of Insurance Regulation (the "Office") to examine all insurers regarding "affairs, transactions, accounts, records, and assets." Section 627.9175, F.S., reads, in part, "Each health insurer, prepaid limited health services organization, and health maintenance organization shall submit, no later than April 1 of each year, to the office information concerning health and accident insurance coverage and medical plans being marketed and currently in force in this state."

The required filers include the following Florida Certification of Authority Categories:

(1) FRATERNAL BENEFIT SOCIETY
(2) PROPERTY AND CASUALTY INSURER
(3) HEALTH MAINTENANCE ORGANIZATION (HMO)
(4) PRE-PAID LIMITED HEALTH SERVICE ORGANIZATION
(5) LIFE AND HEALTH INSURER

having one or more of the following Florida Lines of Business active during the calendar reporting year:

a. FRATERNAL HEALTH
b. ACCIDENT AND HEALTH
c. DENTAL SERVICE PLAN CORPORATION (PREPAID DENTAL)
d. AMBULANCE SERVICE
e. OPTOMETRIC SERVICES
f. PHARMACEUTICAL SERVICES
g. HEALTH MAINTENANCE ORGANIZATIONS
h. PREPAID LIMITED HEALTH SERVICE ORGANIZATION
i. MENTAL HEALTH SERVICES
j. SUBSTANCE ABUSE SERVICES
k. CHIROPRACTIC SERVICES
l. PODIATRIC CARE SERVICES
m. MISC. – PLHSO
n. LIFE
o. VARIABLE ANNUITIES
p. GROUP LIFE AND ANNUITIES
q. VARIABLE LIFE
r. FRATERNAL LIFE

The electronic filing via the Industry Portal (https://irfs.fldfs.com/) of this information is required pursuant to Section 627.316, F.S., and Rules 69O-137.004 and 69O-154.112(3), Florida Administrative Code.

Specific instructions on the use of the Industry Portal's Data Reporting module are available upon request from **GAPReporting@floir.com**

"**NO DATA FILING**" is to be used if the reporting entity had

- **no direct Florida health premiums (written or earned) during the calendar reporting ye**

AND

- **no direct Florida health losses incurred during the calendar reporting year**

AND

- **no enrolled Florida resident groups or primary insureds as of December 31st of the calendar reporting year.**

AND

- **no life insurance policies or annuity contracts in force in the State of Florida as of December 31st of the calendar reporting year.**

"DATA FILING" is to be used by all other reporting entities. The data template contained in this category includes

(1) ***Report of Gross Annual Premiums and Enrollment Data for Health Benefit Plans Issued to Florida Residents*** **, OIR-B2-1094**

(2) ***Report of Life Insurance and Annuity business in the State of Florida under the Life_Annuity tab***

IF YOU HAVE ADDITIONAL QUESTIONS CONTACT THE MARKET DATA COLLECTION SECTION AT 850-413-3147 OR EMAIL TO:

GAPReporting@floir.com

Row Definitions: GAP_1094

TYPE OF INSURANCE DESCRIPTION	TOI or Sub-TOI Code per NAIC Uniform Coding Matrix (Revised 1/1/05)
Major Medical - A hospital/surgical/medical expense contract that provides comprehensive benefits as defined in the state in which the contract will be delivered. In Florida this 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 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 do not 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. **Hospital/Surgical/Medical Expense** - An insurance contract that provides coverage to or reimburses the covered person for hospital, surgical, and/or medical expense incurred as a result of injury, sickness, and/or medical condition. These definitions include the following subcategories: • ***Guarantee Issue (HIPAA, FS 627.6487(3))*** • ***Individually Underwritten*** • ***Self-Employed or Sole Proprietor (FS 627.6699)*** • ***2 - 50 Member Groups (FS 627.6699)*** • ***51 - 100 Member Groups (FS 627.6699)*** • ***101+ Member Groups (FS 627.652)*** The coverages themselves are collected under four categories containing the following: • ***ACA Major Medical and/or Hospital/Surgical/Medical Expense Coverages Issued to In-State Groups -- On Exchange Only*** • ***ACA Major Medical and/or Hospital/Surgical/Medical Expense Coverages Issued to In-State Groups -- Off Exchange*** • ***Grandfathered Major Medical and/or Hospital/Surgical/Medical Expense Coverages Issued to In-State Groups*** • ***Transitional Major Medical and/or Hospital/Surgical/Medical Expense Coverages Issued to In-State Groups*** • ***Grandfathered Major Medical and/or Hospital/Surgical/Medical Expense Coverages Issued to Out-of-State Groups as defined in Section 627.6515, F.S.*** • ***Transitional Major Medical and/or Hospital/Surgical/Medical Expense Coverages Issued to Out-of-State Groups as defined in Section 627.6515, F.S.***	**H16G** **H16I** **H15G** **H15I**
Conversion - Guarantees an insured whose coverage is ending for specified reasons a right to purchase a policy without presenting evidence of insurability.	**H06**
Other Prepaid Health Services not listed below: Pursuant to Section 636.003(5), F.S., "Limited health service" also includes ambulance services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services. "Limited health service" does not include inpatient, hospital surgical services, or emergency services except as such services are provided incident to the limited health services.	
Administrative Services Only (ASO) - ASO describes the contractual arrangement utilized by a self-funded employer, whereby a separate company processes claims and other administrative needs pertinent to the employer's health care plans. (Please report fees in "Total Direct Premiums Earned" and "Direct Premiums Earned for New Business Only" and "Covered Lives")	
Accident Only - An insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident.	**H02G** **H02I**
Accidental Death & Dismemberment - An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.	**H03G** **H03I**
Blanket Accident/Sickness -- A health insurance contract that covers all of a class of persons not individually Identified in the contract.	**H04**
Dental - Insurance that provides benefits for routine dental examinations, preventive dental work and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.	**H10G** **H10I**

TYPE OF INSURANCE DESCRIPTION	TOI or Sub-TOI Code per NAIC Uniform Coding Matrix (Revised 1/1/05)
Disability Income (includes Business Overhead Expense; Short Term; Long Term; and Combined Short Term and Long Term) - A policy designed to compensate insureds for a portion of the income they lose because of a disabling injury or illness.	**H11G** **H11I**
Excess/Stop Loss (includes Accident & Sickness; Managed Care; Provider; and Self-Funded Health Plan) - This type of insurance may be extended to either a health plan or a self-insured employer plan. Its purpose is to insure against the risk that any one claim will exceed a specific dollar amount or that an entire plan's losses will exceed a specific amount. As defined in Section 627.6482 (14), F.S., "Stop-loss coverage" means an arrangement whereby an insurer insures against the risk that any one claim will exceed a specific dollar amount or that an entire self-insurance plan's losses will exceed a specific amount.	**H12**
Hospital Indemnity - An insurance contract that pays a fixed dollar amount without regard to the actual expense incurred for each day the covered person is confined to the hospital as a result of injury, sickness, and/or medical condition.	**H14G** **H14I**
Limited Benefit (includes Specified Disease; Critical Illness; Dread Disease; Dread Disease – Cancer Only; HIV Indemnity; Intensive Care; and Organ & Tissue Transplant)- (a) Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or a principle sum. (b) Provides a daily benefit for confinement in a qualified intensive care unit of a certified hospital. Benefits are specific to services delivered by the staff of a hospital intensive care unit. Benefits not to exceed a stated dollar amount per day. (c) Provides benefits for services incurred as a result of human and/or non-human organ transplant. Benefits are specific to the delivery of care associated with the covered organ or tissue transplant. Benefits not to exceed a stated dollar amount per day.	**H07G** **H07I** **H08G** **H08I** **H09G** **H09I**
Long Term Care-Comprehensive -- Coverage that provides both facility (nursing home) and non-facility (home health care) benefits. This includes products that offer one type of benefit through a base form and the second type through a rider. All extension of benefit riders providing comprehensive coverage are included.	**LTC05G** **LTC05I**
Long Term Care-Facility Only -- Coverage that provides only facility (nursing home) benefits. All extension of benefit riders providing facility only coverage are included.	**LTC04G** **LTC04I**
Long Term Care-Non-Facility Only -- Coverage that provides only non-facility (home health care) benefits. All extension of benefit riders providing non-facility only coverage are included.	**LTC02G** **LTC02I**
Long Term Care-Accelerated Benefit Rider -- Coverage that provides any type of long term care benefit paid from either a life or annuity product.	**FLLTC06**
Short Term Care (includes Home Health Care; Nursing Home; and Adult Day Care) - Coverage that provides medical and other services to insured's who need constant care in their own home or in a nursing facility for periods of less than one year.	**H13G** **H13I**
Medicare Supplement - Insurance coverage sold on a individual or group basis to help fill the "gaps" in the protections granted by the federal Medicare program. This is strictly supplemental coverage and cannot duplicate any benefits provided by Medicare. It is structured to pay part or all of Medicare's deductibles and co-payments. It may also cover some services and expenses not covered by Medicare. Also known as "Medigap" insurance.	**MS02G** **MS02I** **MS03G** **MS03I** **MS04G** **MS04I** **MS05G** **MS05I** **MS06**

TYPE OF INSURANCE DESCRIPTION	TOI or Sub-TOI Code per NAIC Uniform Coding Matrix (Revised 1/1/05)
Medicare Advantage (Medicare+Choice) - Also known as Medicare Part C, includes the private health plans through which beneficiaries have chosen to receive all of their Medicare benefits. It includes: (i) Coordinated care plans such as Health Maintenance Organizations (HMOs), provider-sponsored organizations (PSOs), regional or local preferred provider organizations (PPOs), and other network plans (other than private fee-for-service plans) [42 C.F.R.§422.4(a)(1)(iii).] (ii) Private Fee for Service Plans [42 C.F.R. §422.4(a)(3).] and (iii) Medical savings accounts which are comprised of an MA medical savings account plan that pays for a basic set of health benefits approved by CMS and an MSA trust or custodial account into which CMS will make deposits. [42 C.F.R. §422.4(a)(2).]	**N/A**
Champus/Tricare Supplement - Civilian Health and Medical Program of the Uniformed Services (Champus). A private health plan that provides beneficiaries eligible for Champus with supplemental health care coverage.	**H05**
Prescription Drug - Prescription drug plan that covers the cost of drugs (except those dispensed in a hospital or in an extended care facility) that are required by either state or federal law to be dispensed by prescription. Drugs for which prescriptions are not required by law may be covered.	**H17G** **H17I**
Sickness - Limited benefit expense policies. Provides benefits for sickness only. Benefits not to exceed a stated dollar amount per day.	**H18G** **H18I**
Student - A health insurance contract that covers a class of students not individually identified in the contract.	**H04.001**
Travel - Limited benefit expense policies. Provides benefits for loss incurred while traveling generally outside a 100-mile radius of the US borders. *May extend to domestic as well as foreign travel. May provide both sickness and injury benefits. May include loss of baggage benefits. May include air transportation services for emergencies. Benefits not to exceed a stated dollar amount per day, per month or trip duration. (*Subject to applicable state limitations.)	**H19G** **H19I**
Vision - Limited benefit expense policies. Provides benefits for eye care and eye care accessories. Generally provides a stated dollar amount per annual eye examination. Benefits often include a stated dollar amount for glasses and contacts. May include surgical benefits for injury or sickness associated with the eye.	**H20G** **H20I**
Other - **includes** Prepaid Health Services not listed above (including ambulance services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services), Champus/Tricare Supplement, Travel, Student coverages	**H21** **Other**
Misc. - include the following: HCPP, Medicaid (All Titles), SCHIP, FEHBP, Florida Healthy Kids, Florida Health Flex Plans, self-insured business **Do Not Include**: credit (group and individual), or credit A&H (group and individual)	
Accident and Health Insurance Premiums and Losses - The Total Direct Premiums Earned and the Total Direct Losses Incurred from the company's Annual Statement are entered and compared to the premium and loss sums from lines 1 through 24. These amounts should equal or an explanatory letter will be required.	

Please note that as defined in Section 627.6482(12), premium means the entire cost of an insurance plan, including the administrative fee, the risk assumption charge, and, in the instance of a minimum premium plan or stop-loss coverage, the incurred claims whether or not such claims are paid directly by the insurer.

Beginning January 1, 2013, the Office no longer requires that Discount Medical Plan Organization premium, loss, or enrollment information be reported on the 1094 template.

For each of the health coverage types listed above, the following information is required:

Column Definitions:

TOTAL DIRECT PREMIUMS EARNED	Requested data is your company's direct premium earned from January 01 through December 31, inclusive, for the calendar reporting year. Provide only earned premium specific to covered Florida residents. This cell should contain a whole number or zero.
DIRECT LOSSES INCURRED	Requested data is your company's direct losses incurred from January 01 through December 31, inclusive, for the calendar reporting year. Provide only losses specific to covered Florida residents. This cell should contain a whole number or zero.
RATIO OF DIRECT LOSSES INCURRED TO DIRECT PREMIUMS EARNED	This is an auto-calculation field. It divides [DIRECT LOSSES INCURRED] by [TOTAL DIRECT PREMIUMS EARNED].
WAS THIS COVERAGE ACTIVELY TRANSACTED DURING THE REPORTING PERIOD?	This cell is used to indicate whether or not your company sold any policies of the associated coverage in each row during the calendar reporting year. A policy is considered to be sold if it meets the definition of an insurance transaction per Section 624.10, F.S. Responding "YES" means sales did occur during the calendar reporting year. Responding "NO" means sales did not occur during the calendar reporting year.
DIRECT PREMIUMS EARNED FOR NEW BUSINESS ONLY	Requested data is your company's direct premium earned for new business only from January 01 through December 31, inclusive, for the calendar reporting year. Provide earned premium specific to covered Florida residents. The data contained in this cell should be included in the total reported for "TOTAL DIRECT PREMIUMS EARNED." This cell should contain a whole number or zero. If the coverage associated with this cell was sold during the calendar reporting year, this cell should be entered as a whole number or zero. Otherwise, please enter zero.
PERCENTAGE OF NEW BUSINESS PREMIUMS TO TOTAL PREMIUMS	This is an auto-calculation field. It divides [DIRECT PREMIUMS EARNED FOR NEW BUSINESS ONLY] by [TOTAL DIRECT PREMIUMS EARNED] then multiplies the result by 100 to convert it to a percentage.
EMPLOYEES/GROUPS, IF GROUP COVERAGE, AT END OF REPORTING CY	For all group categories, provide the number of employers who covered Florida resident employees, as of December 31 for the calendar reporting year. This cell should contain a positive, whole number or zero.
PRIMARY ENROLLEES AT END OF REPORTING CY	Provide the total number of resident individual policyholders or resident group employee/member certificateholders, as of December 31 for the calendar reporting year. This cell should contain a positive, whole number or zero.

COVERED ENROLLEE DEPENDENTS AND JOINT PRIMARY INSUREDS AT END OF REPORTING CY	Provide the total number of individuals who are covered by the primary insured's plan (excluding the primary insured but including additional joint primary insureds) and who receive coverage due to his/her dependent relationship to the primary insured, as of December 31 for the calendar reporting year. This cell should contain a positive, whole number or zero.
COVERED LIVES AT END OF REPORTING CY	This is an auto-calculation field. It adds [PRIMARY ENROLLEES AT END OF REPORTING CY] and [COVERED ENROLLEE DEPENDENTS AND JOINT PRIMARY INSUREDS AT END OF REPORTING CY]
AVERAGE NUMBER OF DAYS TAKEN TO PAY CLAIMS	Provide a simple average ([the total number of days from the date of receipt to the date of payment for each claim received] divided by [the total of number of claims received]). The data provided should be specific to covered Florida residents and only include all paid, denied, or contested claims with original paid dates in the year being reported. Where claim is defined by Section 627.6131(2) and 641.3155(1), F.S. Where date of receipt is defined by Section 627.6131(3)(a) and 641.3155(2)(a), F.S. Where date of payment is defined by Section 627.6131(7) and 641.3155(6), F.S. This cell should contain a positive, whole number or zero.

Column Definitions: Life_Annuity

TYPE OF INSURANCE DESCRIPTION
Annual Renewable Term - Insurance coverage for one year that can continue at the option of the policy owner at the start of each future anniversary for one additional year until a final expiry age or date as long as premiums defined contractually are paid when due or within a grace period.
Level Premium Term - insurance for coverage periods of more than one year such as ten, fifteen, twenty, or thirty years where premiums during the coverage period remain the same on each premium due date.
Credit Decreasing Term - credit life insurance (as defined in 627.677, means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.) where coverage decreases from an initial amount, such as the amount at which purchase of an automobile was financed, at either constant amounts each period (usually monthly) or according to a formula such as an amortization schedule.
Group Term - term insurance sold to a group that provides coverage to members of the group and often includes optional dependent coverage with amounts specified in certificates issued to each covered member.
Fixed UL - universal life insurance with fixed premiums.
Indexed UL - universal life insurance where interest credited to the fund balance is based upon the increase in an external index such as the Standard and Poors 500.
Variable UL - a variable contract form of universal life insurance, as defined in 627.8015, where increases or decreases to the fund balance (and under a common option, if elected, the death benefit) are based on the performance of assets held in a separate account.
Whole Life - a contract where coverage continues for the life of the insured as long as premiums are paid when due.
Variable Life - a variable contract form of whole life insurance, as defined in 627.8015, where increases or decreases to contract values are based on the performance of assets held in a separate account.
Industrial Policies - as defined in 627.502, that form of life insurance written under policies under which premiums are payable monthly or more often, bearing the words “industrial policy” or “weekly premium policy” or words of similar import imprinted upon the policies as part of the descriptive matter, and issued by an insurer which, as to such industrial life insurance, is operating under a system of collecting a debit by its agent.
Fixed Deferred Non-Qualified Annuity - a fixed deferred annuity not used to fund a tax-advantaged retirement plan or IRA.
Fixed Deferred Qualified Annuity - a fixed deferred annuity used to fund a tax-advantaged retirement plan or IRA.
Fixed Immediate Annuity - a fixed annuity that pays a guaranteed income that starts almost immediately.
Variable Deferred Non-Qualified Annuity - a variable contract form of Deferred Non-Qualified Annuity, as defined in 627.8015, where increases or decreases to fund values are based on the performance of assets held in a separate account.
Variable Deferred Qualified Annuity - a variable contract form of Deferred Qualified Annuity, as defined in 627.8015, where increases or decreases to fund values are based on the performance of assets held in a separate account.
Variable Immediate Annuity - a variable contract form of Immediate Annuity, as defined in 627.8015, where increases or decreases to periodic payments to an annuitant are based on the performance of assets held in a separate account.

For each of the life and annuity coverage types listed above, the following information is required:

Row Definitions:

NAIC Line Numbers 1-15 and 20-23	Definitions for these rows can be found in the NAIC instructions for the exhibits Life Insurance Part 1 and Life Insurance Part 2.
New Issue Single Premium (Amount)	Face amount of New Issue Single Premium Life Insurance collected during the year.
New Issue Single Premium (Number of Policies)	Number of single premium Life Insurance Policies issued during the year.
New Issue Resulting from Replacements (Amount)	Face amount of New Issue Life Insurance issued during the year where a previous in force policy was cancelled and replaced by a new one.
New Issue Resulting from Replacements (Number of Policies)	Number of policies issued during the year which replaced a previous in force policy which was cancelled.
New Issue Resulting from Conversions (Amount)	Face amount of policies issued during the year where coverage (group or individual) was replaced by a conversion policy. Two common examples are coverage under a group term Certificate converted to an individual policy and individual term insurance converted to whole life.
New Issue Resulting from Conversions (Number of Policies)	Number of policies issued during the year where coverage (group or individual) was replaced by a conversion policy.
Lapses During the Year (Amount)	Face amount of policies cancelled from in force insurance for non payment of a required premium following the grace period permitted for late payment.
Lapses During the Year (Number of Policies)	Number of policies cancelled from in force insurance for non payment of a required premium following the grace period permitted for late payment.
Expired During the Year (Amount)	Face amount of policies cancelled from in force insurance due to reaching the end of the period of coverage.
Expired During the Year (Number of Policies)	Number of policies cancelled from in force insurance due to reaching the end of the period of coverage.
Surrenders Paid During the Year (Amount)	Benefits paid on policies terminated from in force insurance at the request of the policy owner.
Surrenders Paid During the Year (Number of Policies)	Number of policies where benefits were paid on policies terminated from in force insurance at the request of the policy owner.
Number of Policies where Insurance was Increased During the Year	Number of policies where the amount of insurance was increased at the request of the policy owner.
Number of Policies where Insurance was Decreased During the Year	Number of policies where the amount of insurance was decreased at the request of the policy owner.
Total Covered Lives (including riders)	Total number of persons covered under base policy coverage and those whose coverage is provided by policy riders

Data Submission Validation Process

Computerized Validations:

There are two stages of data validation performed on your data template before it can be received by the Office.

The first of these are built into the data template itself. As you navigate the template, you will be given various "Validation Assistance" alerts. For example, if a type of coverage is defined as GROUP coverage, you will receive an alert as you begin to enter data in the [EMPLOYERS/GROUPS, IF GROUP COVERAGE, AT END OF REPORTING CY] cell that reads: "If the number of Employers/Groups reported is zero, then the number of Primary Enrollees and the number of Covered Enrollee Dependents must also be zero." If you enter zero in the cell, the data template will will not allow you to enter anything but zero in the [PRIMARY ENROLLEES AT END OF REPORTING CY] and [COVERED ENROLLEE DEPENDENTS AND JOINT PRIMARY INSUREDS AT END OF REPORTING CY] cells.

The second stage of computerized validations is performed at the time you submit your data template. These validations are performed "behind the scenes" by the Office's computer system. These checks notify you by email if you have missed a required cell or made a similar type of data entry error on the data template. At the time your email notification is sent, your data template is returned to your Industry Portal workbench area so that corrections can be made. If you feel you need assistance with the corrections, please contact the Office via email at: **GAPReporting@floir.com**

Reviewer Validations:

Once your data submission reaches the Office, a staff member rechecks your data for reasonability. This can include comparing your submitted data to other sources and previous data submission received from your company.

If the reviewer has a question or needs clarification, he/she will contact you by email or phone. This clarification letter will reference the "file log number" assigned to your data submission by the Office. This tracking number will be used on all communication from the Office about your data.

Once the reviewer is satisfied with your data submission, you will receive a final disposition letter by email which closes your data submission filing. Final disposition you will see in these letters include:

1. **FILING NOT REQUIRED:** This means your company is not required to report this data. No further action will be needed on your part.
2. **SUBMISSION ERROR:** This means your submission does not meet the filings standards for this specific reporting requirement. Depending on the type of error your submission contained, you may or may not need to resubmit your data under another Office tracking number.
3. **EXEMPT:** This final disposition means your submission of "NO DATA" meets the reporting requirement for this reporting period. No further action will be needed on your part for the reporting period covered by your data submission. Please note: Receiving an exemption letter does not preclude the necessity of filing additional data or no data filings in the future. In most cases, your company will need to continue to file each reporting period.
4. **WITHDRAWN:** This means your company requested your submission under the assigned file log number be closed by the Office. In most cases, this is done so that you can "start from scratch" and re-file your data under a new file log number.
5. **ACCEPTED:** A final disposition letter of acceptance means that the reviewer has completed his/her reasonability checks and feels your data submission is valid. No further action is required at this time.
6. **REFERRED:** This type of letter means that based on the data submitted and any additional information provided, your data submission will be referred to the Office's Market Investigation Unit for additional follow up.