DEPARTMENT OF FINANCIAL SERVICES

Office of Insurance Regulation – Bureau of Life & Health Forms and Rates

UNIVERSAL STANDARDIZED DATA LETTER

What is the purpose of this filing?
(Check one)

- ☐ Forms Only
- ☐ Forms & Rates
- ☐ Rates Only
- ☐ Annual Rate Certification (no rate or benefit changes)

Company Information:

FEIN ______________________ NAIC Company Code ________

Company Name ______________________

SECTION I. INSTRUCTIONS AND INFORMATION

This online form must accompany all Life & Health Form or Rate filings submitted to the Office. If you have questions regarding the information requested, please consult our website at www.floir.com or contact us at (850) 413-3152.

SECTION II. CONTACT INFORMATION

Preferred Email Address:
(for all correspondence)

- ☐ I-Portal Account Email
- ☐ Filing Originator Email
- ☐ Company Contact Email
- ☐ Other

Additional Email Addresses:

Filing Originator Information

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Contact Name: ______________________ Contact Title: ______________________

Professional Designation: ______________________ Contact Email: ______________________

Street Address: ______________________ Suite/Room #: ______________________

P.O. Box Mailing Address: ______________________

DEPARTMENT OF FINANCIAL SERVICES

Office of Insurance Regulation – Bureau of Life & Health Forms and Rates

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Department: ____________________

City: ____________________ State: __________ Zip Code: ________ - ____

Country: ____________________ Non US Postal Code: ____________________

Phone Number: __________ Ext ______ Fax Number: ____________________

Toll Free Number: __________ Ext ______ Non US Phone Number: ____________________

Company Contact Information

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Contact Name: ____________________ Contact Title: ____________________

Professional Designation: ____________________ Contact Email: ____________________

Street Address: ____________________ Suite/Room #: ____________________

P.O. Box Mailing Address: ____________________

Department: ____________________

City: ____________________ State: __________ Zip Code: ________ - ____

Country: ____________________ Non US Postal Code: ____________________

Phone Number: __________ Ext ______ Fax Number: ____________________

Toll Free Number: __________ Ext ______ Non US Phone Number: ____________________

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Rev. 8/12

SECTION III. GENERAL INFORMATION

A. Do you currently have in force business on this plan of insurance in Florida? ☐Yes ☐No

B. Are you currently selling this plan in other states? ☐Yes ☐No

C. What market restrictions (such as available to military persons only), do you have on this form? _____

D. Is this filing a resubmission of a previously disapproved, withdrawn or incomplete filing? ☐Yes ☐No
If yes, provide Florida file log number: _____

E. Type of company: ☐Profit ☐Non-profit

SECTION IV. LIFE & HEALTH INSURANCE

A. Your policy or coverage is (check one)
- ☐ Health
- ☐ Life
- ☐ Variable Life
- ☐ Annuity
- ☐ Variable Annuity

B. Your policy or coverage is (Check one) ☐ Fraternal ☐ Individual ☐ Group

C. Group Policy Characteristics

1) ☐ In-state ☐ Out-of-state

2) ☐ Large Group Only ☐ Small Group Only (Major Medical - see section 627.6699, F.S.) ☐ Small Group Only (Other than Major Medical)
☐ Small and Large Groups (Other than Major Medical)

3) ☐ Employee Group ☐ Labor Union Group ☐ Debtor Group
☐ Association Group ☐ Additional Group ☐ Other (specify) _____

4) ☐ Blanket Health Policy ☐ Franchise Health Policy
☐ A group to cover persons associated in any other common group, which common group is formed primarily for purposes other than providing insurance.
☐ A group which is established primarily for the purpose of providing group insurance.
☐ A group of insurance agents of an insurer, which insurer is the policyholder.
☐ Other (specify) _____

D. Individual Policy Characteristics

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☐ Optionally Renewable ☐ Guaranteed Renewable ☐ Non-Renewable
☐ Conditionally Renewable ☐ Non-Cancelable ☐ Other (specify) _____

E. Is your Policy or Coverage primarily for individuals over 65? ☐ Yes ☐ No

F. Check the types of benefit(s) your policy or coverage provides:

☐ Disability Income
☐ Long Term Care
☐ Medicare Supplement
☐ Health Maintenance Organization
☐ Major Medical
☐ Prepaid Limited Health Service Organization
☐ Small Employer Group Coverage (see Section 627.6699, F.S.)
☐ Other (specify)

SECTION V. RATE FILING HISTORY – INCLUDING ANNUAL RATE CERTIFICATIONS

(This section is for Florida experience only; not applicable for new form filings)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
		Total Annualized Premium Volume	# of Group Certificates or Individual Policies	Average Rate Change Requested (0.0% for ARC Filings)	Minimum Rate Change Requested (0.0% for ARC Filings)	Maximum Rate Change Requested (0.0% for ARC Filings)	Average Benefit Change Requested (0.0% for ARC Filings)			Effective Date of Change (N/A for ARC Filings)
Current Filing		$								
	Average Rate Change Requested	Total Annualized Premium Volume	# of Group Certificates or Individual Policies	Average Rate Change Approved	Minimum Rate Change Approved	Maximum Rate Change Approved	Average Benefit Change Approved	Date Change Approved or Acknowledged	Florida Filing Number	Effective Date of Change
1st Prior Filing	%	$		%	%	%	%			
2nd Prior Filing	%	$		%	%	%	%			

NOTE: Dates for columns (8) and (10) must be in the format mm/dd/yyyy.

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SECTION VI. RATE REQUEST BY FORM – INCLUDING NEW FORM SUBMISSIONS

(To be completed for all rate filings, including ARC filings - Florida experience only.)

(1) Form Number	(2) Base Form or Rider	(3) Marketing Product Name (Street Name)	(4) Average Rate Change Requested (0.0% for ARC Filings)	(5) Minimum Rate Change Requested (0.0% for ARC Filings)	(6) Maximum Rate Change Requested (0.0% for ARC Filings)	(7) Average Benefit Change Requested (0.0% for ARC Filings)	(8) Total Annualized Premium Volume	(9) Total Incurred Claims	(10) # of Group Certificates or Individual Policies	(11) # of Covered Dependents/ Additional Lives	(12) # of Covered Lives (10+11)	(13) Inception Date or New Form	(14) Discontinued Date (If Applicable)	(15) Number of Member Months (Major Medical Only)	(16) Major Medical Coverage Type (Select All That Apply)
															HMO, PPO, Indemnity, POS, FFS, EPO, HSA, HDHP

MAJOR MEDICAL FORMS ONLY

Please enter one claim per row for each unique incurred claim over $500,000 for last five (5) years by year:

(1) Amount	(2) Incurral Year

SECTION VII. ADDITIONAL DATA FOR ALL RATE FILINGS

(Please provide current data for the form(s) included in the filing and listed in section VI.)

	Florida Only		Nationwide	
			☐ Same as Florida	
A. Number of Group Certificates or Individual Policies				
B. If Group, Average Number of Certificates Per Policy/ Participating Unit (e.g. Employer Unit)				
C. Total Annualized Premium Volume (Prior / Projected)	$	$	$	$
D. Total Incurred Claims (Prior / Projected)	$	$	$	$
E. Average Annual Premium (Current / Proposed or new form)	$	$	$	$
F. Anticipated Loss Ratio (Current / Proposed Premium)	%	%	%	%
G. Lifetime Loss Ratio (Current / Proposed Premium)	%	%	%	%

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H. Target Loss Ratio for Individual or Group Forms (Not the Minimum; Expected Loss Ratio for Annually Rated Groups; Weighted average by form and/or group size where applicable)		%		%
I. Total Past Incurred Loss Ratio Without Active Life Reserve Increases		%		%
J. Latest Calendar Year Loss Ratio for Policies 3 Years & Older (For Med. Supp.) Without Policy Reserves:		%		%
K. Anticipated Actual-to-Expected Loss Ratio (Current / Proposed)	%	%	%	%
L. Lifetime Actual-to-Expected Loss Ratio (Current / Proposed)	%	%	%	%
M. Total Past Actual-to-Expected Loss Ratio		%		%
N. Valuation Date of Data (applies to all data in this section)				

SECTION VIII. Rate Filing Certification

I certify that I am authorized to make this Rate Filing on behalf of the company, further that the information contained in related transmittals and the filing is true, complete, correct, and in compliance with all applicable state laws.

(Check one)

- ☐ I am an actuary
- ☐ I am not an actuary

Name:	Title:

SECTION IX. Readability Certification

If you are not required to certify READABILITY compliance per Section 627.4145, F.S., please complete Section IX by checking the box, typing your name and substituting "READABILITY NOT APPLICABLE" in the title field.

I certify that the filing of this policy meets the requirements of Section 627.4145 (1), Florida Statutes, in the following manner (check one)

- ☐ the policy meets the minimum reading ease test score on the test used or;
- ☐ the score is lower than the minimum required but should be approved in accordance with Subsection 627.4145 (2), Florida Statues.

I acknowledge that the Office may require the submission of further information to verify this certification.

Name:	Title:

SECTION X. Checklist Certification

I have reviewed or supervised the review of the policy form(s) that this filing describes. I hereby certify that the statements made in this filing are in compliance with applicable Florida Statutes and Rules. I further certify it will be revised and/or discontinued if the Office determines that the form(s) does not comply with Florida law.

Name:	Title:

SECTION XI. Forms To Be Reviewed

Please provide the following information for the form(s) submitted with this filing.

Form Title	Form Number	Original Filing Number	Original Form Number