



**OFFICE OF INSURANCE REGULATION**

**Life & Health Product Review**

**UNIVERSAL STANDARDIZED DATA LETTER INSTRUCTIONS**

Only one Universal Standardized Data Letter (UDL) may be provided in each filing. Revised UDLs may be submitted to correct information and will replace any previous submissions within the same filing.

Section I. Instructions and Information

Section II. Contact Information: Provide the requested contact information for both the filing originator and the company contact. Select the preferred email address to be used for all correspondence. Provide additional email addresses to be copied on all correspondence, separated by a semi-colon. This section must be filled out for all filings.

Section III. General Information: This section must be filled out for all filings.

Section IV. Life & Health Insurance: Select the applicable filing and product characteristics.

Section IV.C. Group Policy Characteristics:

|                            | <u>Life groups defined in:</u> | <u>Health groups defined in:</u> |
|----------------------------|--------------------------------|----------------------------------|
| Employee Groups            | Section 627.552, F.S.          | Section 627.653, F.S.            |
| Labor Union Groups         | Section 627.554, F.S.          | Section 627.654, F.S.            |
| Debtor Groups              | Section 627.553, F.S.          | Section 627.655, F.S.            |
| Association Groups         | Section 627.5567, F.S.         | Section 627.654, F.S.            |
| Additional Groups          | Section 627.5565, F.S.         | Section 627.656, F.S.            |
| Blanket Health Insurance   | not applicable                 | Section 627.659, F.S.            |
| Franchise Health Insurance | not applicable                 | Section 627.663, F.S.            |

Section IV.D. Individual Policy Characteristics:

Optionally Renewable:

Renewal can be declined on any individual or group contract at the option of the insurer.

Conditionally Renewable:

Renewal can be declined by class, by geographic area or for stated reasons other than the deterioration of health. The insurer may revise rates on a class basis.

Guaranteed Renewable:

Renewal cannot be declined by the insurer for any reason other than fraud, misrepresentation, failure to pay the premium when due, or expiration of the contract, but the insurer can revise rates on a class basis. (See also Sections 627.6425 & 627.6571, F.S.)

Non-Cancelable:

Renewal cannot be declined for any reason other than fraud, misrepresentation, or failure to pay the premium when due, and that rates cannot be revised by the insurer.

Non-Renewable:

A contractual provision exists which prevents a policy duration of more than a specific period, which shall be no more than one year.

Section V. Rate Filing History – Including Annual Rate Certifications

This section is for Florida experience only and reflects aggregate data. Please provide the information for the current filing and the two most recent rate filings that were either approved or acknowledged, if applicable. For filings submitted on or after the effective date of this form, the data for columns (5) and (7) is not required to be filled in for the two prior filings unless available. Beginning one year following the effective date of this form, the data must be filled in for the first prior filing. Beginning two years following the effective date of this form, the data must be filled in for both prior filings.

(1) Average Rate Change Requested - The percentage increase in the average annualized premium being requested. The average annualized premium should be calculated on the basis of the inforce distribution. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.\* Not applicable to the current filing; requested rate change for current filing is in column (4).

(2) Total Annualized Premium Volume - Total premium volume, on an annualized premium basis, for the inforce



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policies at the valuation date for the related filing.

(3) Number of Group Certificates or Individual Policies - For group coverage, provide the number of certificates/subscribers in force at the valuation date for the related filing. For individual coverage, provide the number of policies at the valuation date for the related filing. The total count should be provided, and should include policies with no premium. Policies in a delinquent status should be included.

(4) Average Rate Change - The average rate revision requested, or for prior filings, the average rate revision approved, expressed as the percentage increase in the average annual premium. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.\*

(5) Minimum Rate Change – The smallest increase (this may be a negative number) due to the filing affecting any specific individual policyholder or group certificateholder. For the current filing, this is the requested value. For any prior filings, this is the approved value. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.\*

(6) Maximum Rate Change - The largest increase (this may be a negative number) due to the filing affecting any specific individual policyholder or group certificateholder. For the current filing, this is the requested value. For any prior filings, this is the approved value. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.\*

(7) Average Benefit Change – The average benefit revision requested, or for prior filings, the average benefit revision approved, expressed as a percentage increase in the benefit schedule. Benefit changes due to changes in duration or aging should not be included.

(8) Date Change Approved or Acknowledged - The date the prior filing was closed. Not applicable to the current filing. Dates must be in mm/dd/yyyy format.

(9) Florida Filing Number – The Florida file log number (ex: 11-12345) which identifies the filing. File log numbers must be in ##-##### format without text. Not applicable to the current filing.

(10) Effective Date of Change – For the current filing, provide the target effective date of the requested rate and/or benefit change. For prior filings, provide the effective date of the approved rate and/or benefit change. Not applicable for filings with no rate or benefit changes. Dates must be in mm/dd/yyyy format.

Section VI. Rate Request By Form – Including New Form Submissions - To be completed for all rate filings. This is all filings that involve a rates section review (ex. Rate Only filings, Forms and Rates filings, ARC filings).

This section is for Florida experience only. Each form included in the filing must be listed individually. Additional form rows may be added. Forms such as applications and outlines of coverage do not need to be listed. This section is intended to capture forms such as policies, certificates, riders, and endorsements. Each form in a series must be listed separately. If the premium or claims for a base policy and a rider cannot be separated, the rider should still be included in this section and the number of individual policyholders or group certificateholders should be provided.

(1) Form Number - The form number of the form being filed. Only one form number should be listed in each row. Riders and endorsements should be included and listed individually separately from the base form. The form number should exactly match the form number on the form; all special characters, spaces, and letters must be included.

(2) Base Form or Rider – Indicate if the form listed is a base form or a rider. For the purposes of this form, endorsements may be considered riders as they are not stand-alone forms.

(3) Marketing Product Name (Street Name) – The name used to market or advertise the form. This is not the form number. Leave blank if not available or known. This field is not required for forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994.

(4) Average Rate Change Requested - The requested percentage increase in the average annual premium for only the applicable form. The average annual premium should be calculated on the basis of the inforce distribution. 0.0% for new forms and annual rate certification filings. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.\*



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(5) Minimum Rate Change Requested - The smallest requested increase (this may be a negative number) affecting any specific individual policyholder or group certificateholder on only the applicable form. 0.0% for new forms and annual rate certification filings. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.\*

(6) Maximum Rate Change Requested - The largest requested increase (this may be a negative number) affecting any specific individual policyholder or group certificateholder on only the applicable form. 0.0% for new forms and annual rate certification filings. Value reflects entire rate change excluding only trend that is implemented more frequently than once in twelve months.\*

(7) Average Benefit Change Requested - The average benefit revision requested on only the applicable form expressed as a percentage increase in the benefit schedule. Benefit changes due to changes in duration or aging should not be included. 0.0% for new forms and annual rate certification filings.

(8) Total Annualized Premium Volume - Total premium volume, on an annualized premium basis, for the inforce policies at the valuation date for the filing for only the applicable form.

(9) Total Incurred Claims – Total amount of claims occurring in the twelve months prior to the valuation date for the filing, whether or not paid during that time, for only the applicable form. This field is not required for forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994. If an exact amount is unavailable, provide an estimate for the twelve month period.

(10) Number of Group Certificates or Individual Policies - For group coverage, provide the number of certificates in force, for only the applicable form, at the valuation date for the filing. For individual coverage, provide the number of policies, for only the applicable form, at the valuation date for the related filing. The total count should be provided, and should include policies with no premium. Policies in a delinquent status should be included. For filings including base and rider forms, the sum of these fields may not equal the total fields in section V and VII because insureds with selected riders will be counted multiple times.

(11) Number of Covered Dependents/Additional Lives – The total number of dependents, excluding primary insureds, and/or the total number of additional lives (ex: for joint coverage with two primary insureds, there is one additional life). This field is not required for forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994. If an exact number is unavailable, provide an estimate.

(12) Number of Covered Lives – Automatically calculated as column (10) plus column (11).

(13) Inception Date or New Form – Provide the date the form was approved or indicate that the form is new. A form is new if it has never been approved by the Office. Dates must be in mm/dd/yyyy format. If the exact date is unknown, a date should be estimated. If only the year is known, enter 01/01 with the estimated year.

(14) Discontinued Date – Provide the date the form was closed to new sales. Leave blank if the form is currently available for sale. Dates must be in mm/dd/yyyy format. If the exact date is unknown, a date should be estimated. If only the year is known, enter 01/01 with the estimated year.

(15) Number of Member Months – Applies to Major Medical coverage only. This field is not required for forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994.

(16) Major Medical Coverage Type – Select all applicable coverage types. Applies to Major Medical coverage only. This field is not required for forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994.

For Major Medical Forms Only, complete the large claims table. There should be only one claim per row. A claim is counted as the first incidence or diagnosis of an event resulting in a covered benefit or series of covered benefits. If an insured has had more than one large claim in a calendar year, the claims should be listed on multiple rows. Additional rows may be added. For small group coverage, exclude claims for 1-life groups.

(1) Amount – Provide the dollar amount of the incurred claim. Please enter only one claim per row.

(2) Incurral Year – Provide the calendar year in which the claim was incurred in YYYY format.



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Section VII. Additional Data For All Rate Filings - To be completed for all rate filings. This is all filings that involve a rates section review (ex. Rate Only filings, Forms and Rates filings, ARC filings).

This section reflects aggregate data for both Florida and Nationwide. Provide current data for the form(s) included in the filing which are listed in section VI. If there is no experience outside of Florida, the nationwide section should be identical to the Florida section. If Florida experience is fully credible, as demonstrated in the filing, then the nationwide loss ratio fields (F, G, H, I, J) and nationwide actual-to-expected loss ratio fields (K, L, M) are not required to be completed. If the company is filing for an annual rate filing exemption on a closed block or if the block includes only forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994, the Florida and nationwide loss ratio fields (F, G, H, I, J) and actual-to-expected loss ratio fields (K, L, M) are not required to be completed. All requests for permanent exemption must provide the experience data necessary to demonstrate compliance with the requirements of Rule 69O-149, F.A.C.

A. Number of Group Certificates or Individual Policies - For group coverage, provide the number of individual certificates or subscribers in force. For individual coverage, provide the number of policies. The total count should be provided, and should include policies with no premium. Policies in a delinquent status should be included.

B. Average Number of Certificates Per Policy – Applies only to group coverage. ( $A \div B$  should yield the number of groups)

C. Total Annualized Premium Volume - Premium volume, on an annualized premium basis, for the current inforce policies at the valuation date for the filing. The prior amount reflects the annualized premium before any rate changes. The projected amount reflects the projected annualized premium twelve months following the effective date for the filing, or a twelve month basis consistent with the company's premium data, taking into consideration lapses (if applicable) and any proposed rate changes, but assumes no new issues. The prior value should equal the sum of column (8) in section VI.

D. Total Incurred Claims - Total dollar amount of claims occurring in a year, whether or not paid during that year. The prior amount reflects the twelve months prior to the valuation date for the filing. The projected amount reflects the twelve months following the effective date for the filing, or a twelve month basis consistent with the company's claim data, taking into consideration lapses (if applicable) and any proposed benefit changes, but assumes no new issues. The prior value should equal the sum of column (9) in section VI. This field is not required if the block includes only forms approved prior to February 1, 1994 and discontinued prior to June 1, 1994.

E. Average Annual Premium - The average annualized premium based on the inforce distribution of policies. The current value should reflect the current average annual premium with no changes. The proposed value should reflect the current value including proposed changes to base premiums; excluding only trend that is implemented more frequently than once in twelve months.\* For new forms, a value should be provided in the proposed field.

F. Anticipated Loss Ratio – The present value of future claims, divided by the present value of future earned premiums. The current value should assume no rate and/or benefit changes. The proposed value should reflect the proposed rate and/or benefit changes. For new forms, a value should be provided in the proposed field.

G. Lifetime Loss Ratio – The present value of incurred claims, past and future, divided by the present value of earned premiums, past and future. The current value should assume no rate and/or benefit changes. The proposed value should reflect the proposed rate and/or benefit changes. For new forms, a value should be provided in the proposed field.

H. Target Loss Ratio – The originally filed lifetime loss ratio standard for the form, established at pricing or revised and approved by the Office, and should be equivalent to the present value of the durational loss ratio curve. Applies to both individual and group coverage. This is not the minimum loss ratio established in Rule. For annually rated group products, this is the expected or anticipated loss ratio. For pooled blocks, this is the weighted average by form and/or group size. For new forms, a value is required.

I. Total Past Incurred Loss Ratio Without Active Life Reserve Increases – The accumulated value of past incurred claims divided by the accumulated value of the past earned premiums.

J. Latest Calendar Year Loss Ratio for Policies 3 Years and Older (for Medicare Supplement) without Policy Reserves – The loss ratio, for the most recently completed calendar year for those policies or certificates which have been in force for 3 or more years.



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K. Anticipated Actual-to-Expected Loss Ratio – The ratio of the actual anticipated loss ratio divided by the future expected loss ratio. This is equivalent to the present value of the projected incurred claims divided by the present value of the future expected incurred claims.

L. Lifetime Actual-to-Expected Loss Ratio – The ratio of the actual lifetime loss ratio divided by the lifetime expected loss ratio. This is equivalent to the present value of the past and projected incurred claims divided by the present value of the past and future expected incurred claims.

M. Total Past Actual-to-Expected Loss Ratio – The ratio of the actual past loss ratio divided by the past expected loss ratio. This is equivalent to the present value of the past incurred claims divided by the present value of the past expected incurred claims.

N. Valuation Date of Data – The point in time at which the data was determined. This date separates the past and future experience.

Section VIII. Rate Filing Certification - A qualified actuary, an officer of the company, or a designated compliance person must certify to the rate information provided.

Section IX. Readability Certification – An officer of the company must certify as to the readability of the forms.

Section X. Checklist Certification – An officer of the company or a designated compliance person must certify that all the information provided is correct.

### Section XI. Forms To Be Reviewed

Form Title - The name of the form, for example "Application for Base Form ABC-FL." If submitting a form, this field is required.

Form number - The form number present on the form being submitted in the filing. If submitting a form, this field is required.

Original Filing Number – The Florida file log number of the filing in which the original form was filed and approved. File log numbers must be in ##-##### format without text.

Original Form Number - The number of the form, which will be discontinued for future sales, that is being replaced, if applicable.

Data that is not required per these instructions may be requested by the Office if such information is necessary for a proper review of the filing. In the event of conflict in the definitions in these instructions, the definitions in Florida Statute and Rule shall prevail.

If a field is not applicable, leave the field blank.

*\* Trend implemented more frequently than once in twelve months is not included. Although this value is not captured in this form, it must be reported in the actuarial memorandum, the factors and associated dates must be in the rate manual, and the value must be taken into account in all appropriate exhibits, loss ratio calculations, and actual-to-expected calculations.*

*For example: The currently approved base rate is \$100. The company requests 9% trend to be implemented quarterly. The rate on the effective date of the filing is \$100 for the first quarter, \$102.18 for the second quarter, \$104.40 for the third quarter, \$106.68 for the fourth quarter, and the next filing will begin with a rate of \$109.*

*Trend implemented once per year, which does not raise the rates in intervals as the year progresses, is included.*

*For example: The currently approved base rate is \$100 and will not be trended throughout the year. In the next filing, the company requests a 9% increase due to trend. The rate on the effective date of the filing is \$109 and will not change throughout the year. The next filing will begin with a rate of \$109. This is the same effect as approving a 9% base rate increase; therefore, trend implemented once per year is included in the all of the requested rate change fields.*

*Note that trend must be requested, justified, and approved before being implemented. Upon approval, the trend, regardless of*



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*how frequently it is implemented, is reflected in the anniversary rate change reported in the filing. Trend is approved for up to twelve months, after which the rates may not change without approval from the Office.*