An act relating to insurance; amending s. 215.555, F.S.; delaying the repeal of a provision exempting medical malpractice insurance premiums from emergency assessments to the Hurricane Catastrophe Fund; delaying the date on and after which medical malpractice insurance premiums become subject to emergency assessments; amending s. 624.408, F.S.; revising the minimum surplus as to policyholders which must be maintained by certain insurers; authorizing the Office of Insurance Regulation to reduce the surplus requirement under specified circumstances; amending s. 624.4085, F.S.; defining the term “surplus action level”; expanding the list of items that must be included in an insurer’s risk-based capital plan; specifying actions constituting a surplus action level event; requiring that an insurer submit to the office a risk-based capital plan upon the occurrence of such event; providing requirements for such plan; preserving the existing authority of the office; amending s. 624.4095, F.S.; excluding certain premiums for federal multiple-peril crop insurance from calculations for an insurer’s gross writing ratio; requiring insurers to disclose the gross written premiums for federal multiple-peril crop insurance in a financial statement; amending s. 626.221, F.S.; exempting certain individuals from the requirement to pass an examination before being issued a license as an agent, customer representative, or adjuster;
amending s. 624.424, F.S.; revising the frequency that
an insurer may use the same accountant or partner to
prepare an annual audited financial report; amending
s. 626.7452, F.S.; removing an exception relating to
the examination of managing general agents; amending
s. 626.854, F.S.; providing statements that may be
considered deceptive or misleading if made in any
public adjuster’s advertisement or solicitation;
providing a definition for the term “written
advertisement”; requiring that a disclaimer be
included in any public adjuster’s written
advertisement; providing requirements for such
disclaimer; providing limitations on the amount of
compensation that may be received for a reopened or
supplemental claim; requiring certain persons who act
on behalf of an insurer to provide notice to the
insurer, claimant, public adjuster, or legal
representative for an onsite inspection of the insured
property; authorizing the insured or claimant to deny
access to the property if notice is not provided;
requiring the public adjuster to ensure prompt notice
of certain property loss claims; providing that an
insurer be allowed to interview the insured directly
about the loss claim; prohibiting the insurer from
obstructing or preventing the public adjuster from
communicating with the insured; requiring that the
insurer communicate with the public adjuster in an
effort to reach agreement as to the scope of the
covered loss under the insurance policy; prohibiting a
public adjuster from restricting or preventing persons
acting on behalf of the insured from having reasonable
access to the insured or the insured’s property;
prohibiting a public adjuster from restricting or
preventing the insured’s adjuster from having
reasonable access to or inspecting the insured’s
property; authorizing the insured’s adjuster to be
present for the inspection; prohibiting a licensed
contractor or subcontractor from adjusting a claim on
behalf of an insured if such contractor or
subcontractor is not a licensed public adjuster;
providing an exception; amending s. 626.8651, F.S.;
requiring that a public adjuster apprentice complete a
minimum number of hours of continuing education to
qualify for licensure; amending s. 626.8796, F.S.;
providing requirements for a public adjuster contract;
creating s. 626.70132, F.S.; requiring that notice of
a claim, supplemental claim, or reopened claim be
given to the insurer within a specified period after a
windstorm or hurricane occurs; providing a definition
for the terms “supplemental claim” or “reopened
claim”; providing applicability; amending s. 627.0613,
F.S.; requiring the office of the consumer advocate to
objectively grade insurers annually based on the
number of valid consumer complaints and other
measurable and objective factors; defining the term
“valid consumer complaint”; amending s. 627.062, F.S.;
requiring that the office issue an approval rather
than a notice of intent to approve following its
approval of a file and use filing; prohibiting the
Office of Insurance Regulation from, directly or
indirectly, prohibiting an insurer from paying
acquisition costs based on the full amount of the
premium; prohibiting the Office of Insurance
Regulation from, directly or indirectly, impeding the
right of an insurer to acquire policyholders,
advertise or appoint agents, or regulate agent
commissions; authorizing an insurer to make a rate
filing limited to changes in the cost of reinsurance,
the cost of financing products used as a replacement
for reinsurance, or changes in an inflation trend
factor published annually by the Office of Insurance
Regulation; providing that an insurer may use this
provision only if the increase from such filing and
any other rate filing does not exceed 10 percent for
any policyholder in a policy year; deleting provisions
relating to a rate filing for financing products
relating to the Temporary Increase in Coverage Limits;
revising the information that must be included in a
rate filing relating to certain reinsurance or
financing products; deleting a provision that
prohibited an insurer from making certain rate filings
within a certain period of time after a rate increase;
deleting a provision prohibiting an insurer from
filing for a rate increase within 6 months after it
makes certain rate filings; specifying the information
that an insurer must include in a rate filing based on
the change in an inflation trend factor published by

CODING: Words stricken are deletions; words underlined are additions.
the Office of Insurance Regulation; requiring that the
office annually publish one or more inflation trend
factors; exempting the inflation trend factors from
rulemaking; providing that an insurer is not required
to adopt an inflation trend factor; requiring the
Office of Insurance Regulation to propose a plan for
developing a website, contingent upon an
appropriation, which provides consumers with
information necessary to make an informed decision
when purchasing homeowners’ insurance; requiring that
the Financial Services Commission review the proposed
plan to implement the website; specifying matters that
the Office of Insurance Regulation must consider in
developing the website; deleting obsolete provisions
relating to legislation enacted during the 2003
Special Session D of the Legislature; amending s.
627.0629, F.S.; providing legislative intent that
insurers provide consumers with accurate pricing
signals for alterations in order to minimize losses,
but that mitigation discounts not result in a loss of
income for the insurer; requiring rate filings for
residential property insurance to include actuarially
reasonable debits that provide proper pricing;
deleting provisions that require the office to develop
certain rate differentials for hurricane mitigation
measures; providing for an increase in base rates if
mitigation discounts exceed the aggregate reduction in
expected losses; requiring the Office of Insurance
Regulation to reevaluate discounts, debits, credits,
and other rate differentials by a certain date; 
requiring the Office of Insurance Regulation, in 
consultation with the Department of Financial Services 
and the Department of Community Affairs, to develop a 
method for insurers to establish debits for certain 
hurricane mitigation measures by a certain date; 
requiring the Financial Services Commission to adopt 
rules relating to such debits by a certain date; 
deleting a provision that prohibits an insurer from 
including an expense or profit load in the cost of 
reinsurance to replace the Temporary Increase in 
Coverage Limits; amending s. 627.351, F.S.; renaming 
the “high-risk account” as the “coastal account”; 
revising the conditions under which the Citizens 
policyholder surcharge may be imposed; providing that 
members of the Citizens Property Insurance Corporation 
Board of Governors are not prohibited from practicing 
in a certain profession if not prohibited by law or 
ordinance; prohibiting board members from voting on 
certain measures; changing the date on which the 
boundaries of high-risk areas eligible for certain 
wind-only coverages will be reduced if certain 
circumstances exist; providing a directive to the 
Division of Statutory Revision; amending s. 627.4133, 
F.S.; authorizing an insurer to cancel policies after 
45 days’ notice if the Office of Insurance Regulation 
determines that the cancellation of policies is 
necessary to protect the interests of the public or 
policyholders; authorizing the Office of Insurance
Regulation to place an insurer under administrative supervision or appoint a receiver upon the consent of
the insurer under certain circumstances; creating s. 627.41341, F.S.; providing definitions; requiring the
delivery of a “Notice of Change in Policy Terms” under certain circumstances; specifying requirements for
such notice; specifying actions constituting proof of notice; authorizing policy renewals to contain a change in policy terms; providing that receipt of payment by an insurer is deemed acceptance of new policy terms by an insured; providing that the original policy remains in effect until the occurrence of specified events if an insurer fails to provide notice; providing intent; amending s. 627.7011, F.S.; requiring that an insurer pay the actual cash value of an insured loss, less any applicable deductible, under certain circumstances; requiring that a policyholder enter into a contract for the performance of building and structural repairs; requiring that an insurer pay certain remaining amounts; restricting insurers and contractors from requiring advance payments for certain repairs and expenses; authorizing an insured to make a claim for replacement costs within a certain period after the insurer pays actual cash value to make a claim for replacement costs; requiring an insurer to pay the replacement costs if a total loss occurs; amending s. 627.70131, F.S.; specifying application of certain time periods to initial or supplemental property insurance claim notices and
payments; amending s. 627.711, F.S.; revising the list
of persons qualified to sign certain mitigation
verification forms for certain purposes; authorizing
insurers to accept forms from certain other persons;
providing requirements for persons authorized to sign
mitigation forms; prohibiting misconduct in performing
hurricane mitigation inspection or completing uniform
mitigation forms causing certain harm; specifying what
constitutes misconduct; authorizing certain licensing
boards to commence disciplinary proceedings and impose
administrative fines and sanctions; providing for
liability of mitigation inspectors; requiring certain
entities to file reports of evidence of fraud;
providing for immunity from liability for reporting
fraud; providing for investigative reports from the
Division of Insurance Fraud; providing penalties;
authorizing insurers to require independent
verification of uniform mitigation verification forms;
creating s. 628.252, F.S.; requiring that every
domestic property insurer notify the office of its
intention to enter into certain agreements, contracts,
and arrangements; prohibiting a domestic property
insurer from entering into such agreements, contracts,
or arrangements unless specified criteria are met;
preserving the existing authority of the office;
providing an appropriation to the Office of Insurance
Regulation and authorizing an additional position;
providing effective dates.
Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (b) of subsection (6) of section 215.555, Florida Statutes, is amended to read:

215.555 Florida Hurricane Catastrophe Fund.—

(6) REVENUE BONDS.—

(b) Emergency assessments.—

1. If the board determines that the amount of revenue produced under subsection (5) is insufficient to fund the obligations, costs, and expenses of the fund and the corporation, including repayment of revenue bonds and that portion of the debt service coverage not met by reimbursement premiums, the board shall direct the Office of Insurance Regulation to levy, by order, an emergency assessment on direct premiums for all property and casualty lines of business in this state, including property and casualty business of surplus lines insurers regulated under part VIII of chapter 626, but not including any workers’ compensation premiums or medical malpractice premiums. As used in this subsection, the term “property and casualty business” includes all lines of business identified on Form 2, Exhibit of Premiums and Losses, in the annual statement required of authorized insurers by s. 624.424 and any rule adopted under this section, except for those lines identified as accident and health insurance and except for policies written under the National Flood Insurance Program. The assessment shall be specified as a percentage of direct written premium and is subject to annual adjustments by the board in order to meet debt obligations. The same percentage shall apply to all policies in lines of business subject to the assessment.
issued or renewed during the 12-month period beginning on the
effective date of the assessment.

2. A premium is not subject to an annual assessment under
this paragraph in excess of 6 percent of premium with respect to
obligations arising out of losses attributable to any one
contract year, and a premium is not subject to an aggregate
annual assessment under this paragraph in excess of 10 percent
of premium. An annual assessment under this paragraph shall
continue as long as the revenue bonds issued with respect to
which the assessment was imposed are outstanding, including any
bonds the proceeds of which were used to refund the revenue
bonds, unless adequate provision has been made for the payment
of the bonds under the documents authorizing issuance of the
bonds.

3. Emergency assessments shall be collected from
policyholders. Emergency assessments shall be remitted by
insurers as a percentage of direct written premium for the
preceding calendar quarter as specified in the order from the
Office of Insurance Regulation. The office shall verify the
accurate and timely collection and remittance of emergency
assessments and shall report the information to the board in a
form and at a time specified by the board. Each insurer
collecting assessments shall provide the information with
respect to premiums and collections as may be required by the
office to enable the office to monitor and verify compliance
with this paragraph.

4. With respect to assessments of surplus lines premiums,
each surplus lines agent shall collect the assessment at the
same time as the agent collects the surplus lines tax required
by s. 626.932, and the surplus lines agent shall remit the
assessment to the Florida Surplus Lines Service Office created
by s. 626.921 at the same time as the agent remits the surplus
taxes to the Florida Surplus Lines Service Office. The
emergency assessment on each insured procuring coverage and
filing under s. 626.938 shall be remitted by the insured to the
Florida Surplus Lines Service Office at the time the insured
pays the surplus lines tax to the Florida Surplus Lines Service
Office. The Florida Surplus Lines Service Office shall remit the
collected assessments to the fund or corporation as provided in
the order levied by the Office of Insurance Regulation. The
Florida Surplus Lines Service Office shall verify the proper
application of such emergency assessments and shall assist the
board in ensuring the accurate and timely collection and
remittance of assessments as required by the board. The Florida
Surplus Lines Service Office shall annually calculate the
aggregate written premium on property and casualty business,
other than workers’ compensation and medical malpractice,
procured through surplus lines agents and insureds procuring
coverage and filing under s. 626.938 and shall report the
information to the board in a form and at a time specified by
the board.

5. Any assessment authority not used for a particular
contract year may be used for a subsequent contract year. If,
for a subsequent contract year, the board determines that the
amount of revenue produced under subsection (5) is insufficient
to fund the obligations, costs, and expenses of the fund and the
corporation, including repayment of revenue bonds and that
portion of the debt service coverage not met by reimbursement
premiums, the board shall direct the Office of Insurance Regulation to levy an emergency assessment up to an amount not exceeding the amount of unused assessment authority from a previous contract year or years, plus an additional 4 percent provided that the assessments in the aggregate do not exceed the limits specified in subparagraph 2.

6. The assessments otherwise payable to the corporation under this paragraph shall be paid to the fund unless and until the Office of Insurance Regulation and the Florida Surplus Lines Service Office have received from the corporation and the fund a notice, which shall be conclusive and upon which they may rely without further inquiry, that the corporation has issued bonds and the fund has no agreements in effect with local governments under paragraph (c). On or after the date of the notice and until the date the corporation has no bonds outstanding, the fund shall have no right, title, or interest in or to the assessments, except as provided in the fund’s agreement with the corporation.

7. Emergency assessments are not premium and are not subject to the premium tax, to the surplus lines tax, to any fees, or to any commissions. An insurer is liable for all assessments that it collects and must treat the failure of an insured to pay an assessment as a failure to pay the premium. An insurer is not liable for uncollectible assessments.

8. When an insurer is required to return an unearned premium, it shall also return any collected assessment attributable to the unearned premium. A credit adjustment to the collected assessment may be made by the insurer with regard to future remittances that are payable to the fund or corporation,
but the insurer is not entitled to a refund.

9. When a surplus lines insured or an insured who has
procured coverage and filed under s. 626.938 is entitled to the
return of an unearned premium, the Florida Surplus Lines Service
Office shall provide a credit or refund to the agent or such
insured for the collected assessment attributable to the
unearned premium prior to remitting the emergency assessment
collected to the fund or corporation.

10. The exemption of medical malpractice insurance premiums
from emergency assessments under this paragraph is repealed May
31, 2013 2010, and medical malpractice insurance premiums shall
be subject to emergency assessments attributable to loss events
occurring in the contract years commencing on June 1, 2013 2010.

Section 2. Section 624.408, Florida Statutes, is amended to
read:

624.408 Surplus as to policyholders required; new and
existing insurers.—

(1) (a) To maintain a certificate of authority to transact
any one kind or combinations of kinds of insurance, as defined
in part V of this chapter, an insurer in this state shall at all
times maintain surplus as to policyholders at least not less
than the greater of:

(a) $1.5 million;

(b) 4 percent of the insurer's total liabilities;

(c) 6 percent of the insurer's liabilities relative to health insurance; or
(d) For all insurers other than mortgage guaranty insurers, life insurers, and life and health insurers, 10 percent of the insurer’s total liabilities.

(e) For property and casualty insurers, $4 million except property and casualty insurers authorized to underwrite any line of residential property insurance.

(f) For a residential property and casualty insurer not holding a certificate of authority before July 1, 2010 on December 1, 1993, $15 million. The insurer is not writing new business, has premiums in force of less than $1 million per year in residential property insurance, or is a mutual insurance company. Following amounts apply instead of the $4 million required by subparagraph (a):


(2) For purposes of this section, liabilities do shall not include liabilities required under s. 625.041(4). For purposes of computing minimum surplus as to policyholders pursuant to s. 625.305(1), liabilities shall include liabilities required under s. 625.041(4).
(3) This section does not require any insurer to have surplus as to policyholders greater than $100 million.

(4) A mortgage guaranty insurer shall maintain a minimum surplus as required by s. 635.042.

Section 3. Present paragraph (q) of subsection (1) of section 624.4085, Florida Statutes, is redesignated as paragraph (r), and a new paragraph (q) is added to that subsection, paragraph (b) of subsection (3) of that section is amended, and subsections (7) through (13) of that section are redesignated as subsections (9) through (15), respectively, and new subsections (7) and (8) are added to that section, to read:

624.4085 Risk-based capital requirements for insurers.—

(1) As used in this section, the term:

(q) “Surplus action level” means a loss of surplus on any quarterly or annual financial report which exceeds 15 percent, or which cumulatively for the calendar year exceeds 15 percent as of the most recent filed quarterly or annual report.

(3)

(b) If a company action level event occurs, the insurer shall prepare and submit to the office a risk-based capital plan, which must:

1. Identify the conditions that contribute to the company action level event;

2. Contain proposals of corrective actions that the insurer intends to take and that are reasonably expected to result in the elimination of the company action level event;

3. Provide projections of the insurer’s financial results in the current year and at least the 4 succeeding years, both in
the absence of proposed corrective actions and giving effect to
the proposed corrective actions, including projections of
statutory operating income, net income, capital, and surplus.
The projections for both new and renewal business may include
separate projections for each major line of business and, if
separate projections are provided, must separately identify each
significant income, expense, and benefit component;

4. Identify the key assumptions affecting the insurer’s
projections and the sensitivity of the projections to the
assumptions; and

5. Identify the quality of, and problems associated with,
the insurer’s business, including, but not limited to, its
assets, anticipated business growth and associated surplus
strain, extraordinary exposure to risk, mix of business, and any
use of reinsurance; and

6. Include, at the request of the office, for a residential
property insurer that conducts any business with affiliates, a
columnar worksheet, which shall include all affiliates who have
contracted with, done business with, or otherwise received
remuneration from the insurer and shall list the following
financial information from the immediately preceding calendar
year, listed separately for each affiliate:
   a. Total assets;
   b. Total liabilities;
   c. Surplus or shareholders equity;
   d. Net income after taxes or distributions made solely for
      satisfying tax liabilities;
   e. Total amounts received or receivable from parents,
      subsidiaries, and affiliates;
f. Total amounts paid or payable to any parent, subsidiaries, and affiliates;
g. Dividends paid or payable to shareholders of common stock;
h. Debt service, including principal and interest, paid on debt incurred to capitalize or recapitalize insurance companies or fund other insurance-related activities; and
  i. Payments made for other contractual obligations to support insurance-related activities.

(7)(a) A surplus action level event includes:

1. The filing of a quarterly or annual statutory financial statement by an insurer, which indicates that the insurer’s total surplus has declined by more than 15 percent from the previous year’s annual statement, or cumulatively for the current year through the most recent quarterly financial statement;

2. The notification by the office to the insurer of an adjusted quarterly or annual financial statement that indicates an event in subparagraph 1., unless the insurer challenges the adjusted quarterly or annual financial statement under subsection (9); or

3. The notification by the office to the insurer that the office has, after a hearing, rejected the insurer’s challenge if an insurer challenges, under subsection (9), an adjusted quarterly or annual financial statement that indicates an event in subparagraph 1.

(b) If a surplus action level event occurs, the insurer must prepare and submit to the office a risk-based capital plan, which must:
1. Identify the conditions that contribute to the surplus action level event;

2. Contain proposals of corrective actions that the insurer intends to take and that are reasonably expected to ultimately result in the elimination of additional surplus losses;

3. Provide projections of the insurer’s financial results in the current year and at least the 2 succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business may include separate projections for each major line of business and, if separate projections are provided, must separately identify each significant income, expense, and benefit component;

4. Identify the key assumptions affecting the insurer’s projections and the sensitivity of the projections to the assumptions;

5. Identify the quality of, and problems associated with, the insurer’s business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and any use of reinsurance;

6. Include, at the request of the office, for a residential property insurer that conducts any business with affiliates, a columnar worksheet, which shall include all affiliates who have received remuneration from the insurer and shall list the following financial information from the immediately preceding calendar year listed separately for each affiliate:

a. Total assets;
b. Total liabilities;
c. Surplus or shareholders equity;
d. Net income after taxes or distributions made solely for satisfying tax liabilities;
e. Total amounts received or receivable from parents, subsidiaries, and affiliates;
f. Total amounts paid or payable to any parent, subsidiaries, and affiliates;
g. Dividends paid or payable to shareholders of common stock;
h. Debt service, including principle and interest, paid on debt incurred to capitalize or recapitalize insurance companies or fund other insurance-related activities; and
i. Payments made for other contractual obligations to support insurance-related activities.

7. Contain, at the request of the office, a recertification of reserves for the insurer prepared by an actuary.

(c) The risk-based capital plan must be submitted:
1. Within 45 days after the surplus action level event; or
2. If the insurer challenges an adjusted quarterly or annual financial statement under subsection (9), within 45 days after notification to the insurer that the office has, after a hearing, rejected the insurer’s challenge.

(8) This section does not limit any existing authority of the office.

Section 4. Subsection (7) is added to section 624.4095, Florida Statutes, to read:

624.4095 Premiums written; restrictions.—
(7) For purposes of this section, s. 624.407, and s.
624.408, with regard to capital and surplus requirements, gross
written premiums for federal multiple-peril crop insurance which
are ceded to the Federal Crop Insurance Corporation or
authorized reinsurers may not be included in the calculation of
an insurer’s gross writing ratio. The liabilities for ceded
reinsurance premiums payable for federal multiple-peril crop
insurance ceded to the Federal Crop Insurance Corporation and
authorized reinsurers shall be netted against the asset for
amounts recoverable from reinsurers. Each insurer that writes
other insurance products together with federal multiple-peril
crop insurance shall disclose in the notes to its annual and
quarterly financial statements, or in a supplement to those
statements, the gross written premiums for federal multiple-
peril crop insurance.

Section 5. Paragraph (n) is added to subsection (2) of
section 626.221, Florida Statutes, to read:
626.221 Examination requirement; exemptions.—
(2) However, no such examination shall be necessary in any
of the following cases:

(n) An applicant for license as a customer representative
with respect to property insurance who has earned the
designation of Certified Insurance Representative (CIR) from the
National Association of Christian Catastrophe Insurance
Adjusters.

Section 6. Subsection (8) of section 624.424, Florida
Statutes, is amended to read:
624.424 Annual statement and other information.—
(8)(a) All authorized insurers must have conducted an
annual audit by an independent certified public accountant and
must file an audited financial report with the office on or
before June 1 for the preceding year ending December 31. The
office may require an insurer to file an audited financial
report earlier than June 1 upon 90 days’ advance notice to the
insurer. The office may immediately suspend an insurer’s
certificate of authority by order if an insurer’s failure to
file required reports, financial statements, or information
required by this subsection or rule adopted pursuant thereto
creates a significant uncertainty as to the insurer’s continuing
eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this
section having direct premiums written in this state of less
than $1 million in any calendar year and fewer than 1,000
policyholders or certificateholders of directly written policies
nationwide at the end of such calendar year is exempt from this
section for such year unless the office makes a specific finding
that compliance is necessary in order for the office to carry
out its statutory responsibilities. However, any insurer having
assumed premiums pursuant to contracts or treaties or
reinsurance of $1 million or more is not exempt. Any insurer
subject to an exemption must submit by March 1 following the
year to which the exemption applies an affidavit sworn to by a
responsible officer of the insurer specifying the amount of
direct premiums written in this state and number of
policyholders or certificateholders.

c) The board of directors of an insurer shall hire the
certified public accountant that prepares the audit required by
this subsection and the board shall establish an audit committee
of three or more directors of the insurer or an affiliated
company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 years consecutively. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to implement this subsection, which rules must be in substantial conformity with the 1998 Model Rule Requiring Annual Audited Financial Reports
adopted by the National Association of Insurance Commissioners or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. No insurer may raise as a defense in any action, any exception to, waiver of, or interpretation of accounting requirements, unless previously issued in writing by an authorized representative of the office.

Section 7. Section 626.7452, Florida Statutes, is amended to read:

626.7452 Managing general agents; examination authority.—
The acts of the managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined as if it were the insurer except in the case where the managing general agent solely represents a single domestic insurer.

Section 8. Effective June 1, 2010, subsection (11) of section 626.854, Florida Statutes, is amended to read:

626.854 “Public adjuster” defined; prohibitions.—The Legislature finds that it is necessary for the protection of the public to regulate public insurance adjusters and to prevent the unauthorized practice of law.

(11)(a) If a public adjuster enters into a contract with an insured or claimant to reopen a claim or to file a supplemental claim that seeks additional payments for a claim that has been previously paid in part or in full or settled by the insurer, the public adjuster may not charge, agree to, or accept any compensation, payment, commission, fee, or other thing of value
based on a previous settlement or previous claim payments by the
insurer for the same cause of loss. The charge, compensation,
payment, commission, fee, or other thing of value may be based
only on the claim payments or settlement obtained through the
work of the public adjuster after entering into the contract
with the insured or claimant. Compensation for a reopened or
supplemental claim may not exceed 20 percent of the reopened or
supplemental claim payment. The contracts described in this
paragraph are not subject to the limitations in paragraph (b).

(b) A public adjuster may not charge, agree to, or accept
any compensation, payment, commission, fee, or other thing of
value in excess of:

1. Ten percent of the amount of insurance claim payments by
the insurer for claims based on events that are the subject of a
declaration of a state of emergency by the Governor. This
provision applies to claims made during the period of 1 year
after the declaration of emergency. After the period of 1 year,
the limitations in subparagraph 2. apply.

2. Twenty percent of the amount of all other insurance
claim payments by the insurer for claims that are not based on
events that are the subject of a declaration of a state of
emergency by the Governor.

The provisions of subsections (5)-(13) apply only to residential
property insurance policies and condominium association policies
as defined in s. 718.111(11).

Section 9. Effective January 1, 2011, section 626.854,
Florida Statutes, as amended by this act, is amended to read:

626.854 “Public adjuster” defined; prohibitions.—The
Legislature finds that it is necessary for the protection of the public to regulate public insurance adjusters and to prevent the unauthorized practice of law.

(1) A “public adjuster” is any person, except a duly licensed attorney at law as hereinafter in s. 626.860 provided, who, for money, commission, or any other thing of value, prepares, completes, or files an insurance claim form for an insured or third-party claimant or who, for money, commission, or any other thing of value, acts or aids in any manner on behalf of an insured or third-party claimant in negotiating for or effecting the settlement of a claim or claims for loss or damage covered by an insurance contract or who advertises for employment as an adjuster of such claims, and also includes any person who, for money, commission, or any other thing of value, solicits, investigates, or adjusts such claims on behalf of any such public adjuster.

(2) This definition does not apply to:

(a) A licensed health care provider or employee thereof who prepares or files a health insurance claim form on behalf of a patient.

(b) A person who files a health claim on behalf of another and does so without compensation.

(3) A public adjuster may not give legal advice. A public adjuster may not act on behalf of or aid any person in negotiating or settling a claim relating to bodily injury, death, or noneconomic damages.

(4) For purposes of this section, the term “insured” includes only the policyholder and any beneficiaries named or similarly identified in the policy.
(5) A public adjuster may not directly or indirectly through any other person or entity solicit an insured or claimant by any means except on Monday through Saturday of each week and only between the hours of 8 a.m. and 8 p.m. on those days.

(6) A public adjuster may not directly or indirectly through any other person or entity initiate contact or engage in face-to-face or telephonic solicitation or enter into a contract with any insured or claimant under an insurance policy until at least 48 hours after the occurrence of an event that may be the subject of a claim under the insurance policy unless contact is initiated by the insured or claimant.

(7) An insured or claimant may cancel a public adjuster’s contract to adjust a claim without penalty or obligation within 3 business days after the date on which the contract is executed or within 3 business days after the date on which the insured or claimant has notified the insurer of the claim, by phone or in writing, whichever is later. The public adjuster’s contract shall disclose to the insured or claimant his or her right to cancel the contract and advise the insured or claimant that notice of cancellation must be submitted in writing and sent by certified mail, return receipt requested, or other form of mailing which provides proof thereof, to the public adjuster at the address specified in the contract; provided, during any state of emergency as declared by the Governor and for a period of 1 year after the date of loss, the insured or claimant shall have 5 business days after the date on which the contract is executed to cancel a public adjuster’s contract.

(8) It is an unfair and deceptive insurance trade practice
pursuant to s. 626.9541 for a public adjuster or any other
person to circulate or disseminate any advertisement,
announcement, or statement containing any assertion,
representation, or statement with respect to the business of
insurance which is untrue, deceptive, or misleading.

(a) For purposes of this section, the following statements,
if made in any public adjuster’s advertisement or solicitation,
shall be considered deceptive or misleading:

1. A statement or representation that invites an insured
policyholder to submit a claim when the policyholder does not
have covered damage to insured property.

2. Any statement or representation that invites an insured
policyholder to submit a claim by offering monetary or other
valuable inducement.

3. A statement or representation that invites an insured
policyholder to submit a claim by stating that there is “no
risk” to the policyholder by submitting such claim.

4. Any statement or representation, or use of a logo or
shield, that would imply or could be mistakenly construed that
the solicitation was issued or distributed by a governmental
agency or is sanctioned or endorsed by a governmental agency.

(b) For purposes of this paragraph, the term “written
advertisement” includes only newspapers, magazines, flyers, and
bulk mailers. The following disclaimer, which is not required to
be printed on standard size business cards, shall be added in
bold print and capital letters in typeface no smaller than the
typeface of the body of the text to all written advertisements
by any public adjuster:

“THIS IS A SOLICITATION FOR BUSINESS. IF YOU HAVE HAD
A CLAIM FOR AN INSURED PROPERTY LOSS OR DAMAGE AND YOU
ARE SATISFIED WITH THE PAYMENT BY YOUR INSURER, YOU
MAY DISREGARD THIS ADVERTISEMENT.”

(9) A public adjuster, a public adjuster apprentice, or any
person or entity acting on behalf of a public adjuster or public
adjuster apprentice may not give or offer to give a monetary
loan or advance to a client or prospective client.

(10) A public adjuster, public adjuster apprentice, or any
individual or entity acting on behalf of a public adjuster or
public adjuster apprentice may not give or offer to give,
directly or indirectly, any article of merchandise having a
value in excess of $25 to any individual for the purpose of
advertising or as an inducement to entering into a contract with
a public adjuster.

(11)(a) If a public adjuster enters into a contract with an
insured or claimant to reopen a claim or to file a supplemental
claim that seeks additional payments for a claim that has been
previously paid in part or in full or settled by the insurer,
the public adjuster may not charge, agree to, or accept any
compensation, payment, commission, fee, or other thing of value
based on a previous settlement or previous claim payments by the
insurer for the same cause of loss. The charge, compensation,
payment, commission, fee, or other thing of value may be based
only on the claim payments or settlement obtained through the
work of the public adjuster after entering into the contract
with the insured or claimant. Compensation for a reopened or
supplemental claim may not exceed 20 percent of the reopened or
supplemental claim payment. The contracts described in this
paragraph are not subject to the limitations in paragraph (b).
(b) A public adjuster may not charge, agree to, or accept any compensation, payment, commission, fee, or other thing of value in excess of:

1. Ten percent of the amount of insurance claim payments by the insurer for claims based on events that are the subject of a declaration of a state of emergency by the Governor. This provision applies to claims made during the period of 1 year after the declaration of emergency. After the period of 1 year, the limitations in subparagraph 2. apply.

2. Twenty percent of the amount of insurance claim payments by the insurer for claims that are not based on events that are the subject of a declaration of a state of emergency by the Governor.

(12) Each public adjuster shall provide to the claimant or insured a written estimate of the loss to assist in the submission of a proof of loss or any other claim for payment of insurance proceeds. The public adjuster shall retain such written estimate for at least 5 years and shall make such estimate available to the claimant or insured and the department upon request.

(13) A public adjuster, public adjuster apprentice, or any person acting on behalf of a public adjuster or apprentice may not accept referrals of business from any person with whom the public adjuster conducts business if there is any form or manner of agreement to compensate the person, whether directly or indirectly, for referring business to the public adjuster. A public adjuster may not compensate any person, except for another public adjuster, whether directly or indirectly, for the principal purpose of referring business to the public adjuster.
(14) A company employee adjuster, independent adjuster, attorney, investigator, or other persons acting on behalf of an insurer that needs access to an insured or claimant or to the insured property that is the subject of a claim shall provide at least 48 hours’ notice to the insured or claimant, public adjuster, or legal representative before scheduling a meeting with the claimant or an onsite inspection of the insured property. The insured or claimant may deny access to the property if this notice has not been provided. The insured or claimant may waive this 48-hour notice.

(15)(a) A public adjuster shall ensure prompt notice of any property loss claim submitted to an insurer by or through a public adjuster or on which a public adjuster represents the insured at the time the claim or notice of loss is submitted to the insurer. The public adjuster shall ensure that notice is given to the insurer, the public adjuster’s contract is provided to the insurer, the property is made available for inspection of the loss or damage by the insurer, and the insurer is given an opportunity to interview the insured directly about the loss and claim. The insurer shall be allowed to obtain necessary information to investigate and respond to the claim. The insurer may not exclude the public adjuster from its in-person meetings with the insured. The insurer shall meet or communicate with the public adjuster in an effort to reach agreement as to the scope of the covered loss under the insurance policy. This section does not impair the terms and conditions of the insurance policy in effect at the time the claim is filed.

(b) A public adjuster may not restrict or prevent an insurer, company employee adjuster, independent adjuster,
attorney, investigator, or other person acting on behalf of the insurer from having reasonable access at reasonable times to any insured or claimant or to the insured property that is the subject of a claim.

(c) A public adjuster may not act or fail to reasonably act in any manner that would obstruct or prevent an insurer or insurer’s adjuster from timely gaining access to conduct an inspection of any part of the insured property for which there is a claim for loss or damage to the property. The public adjuster that represents the insured may be present for the insurer’s inspection of the property loss or damage but, if the lack of availability of the public adjuster would otherwise delay the access to or the inspection of the insured property by the insurer, the public adjuster or the insured must allow the insurer to gain access to the insured property to facilitate the insurer’s prompt inspection of the loss or damage without the participation or presence of the public adjuster or insured.

(16) A licensed contractor under part I of chapter 489, or a subcontractor, may not adjust a claim on behalf of an insured without being licensed and compliant as a public adjuster under this chapter. However, if asked by the residential property owner who has suffered loss or damage covered by a property insurance policy, or the insurer of such property, a licensed contractor may discuss or explain a bid for construction or repair of covered property if the contractor is doing so for usual and customary fees applicable to the work to be performed as stated in the contract between the contractor and the insured.
The provisions of subsections (5)-(16) apply only to
residential property insurance policies and condominium unit
owner association policies as defined in s. 718.111(11).

Section 10. Effective January 1, 2011, present subsections
(7) through (11) of section 626.8651, Florida Statutes, are
redesignated as subsections (8) through (12), respectively, and
a new subsection (7) is added to that section, to read:

626.8651 Public adjuster apprentice license;

(7) A public adjuster apprentice shall complete a minimum
of 8 hours of continuing education specific to the practice of a
public adjuster, 2 hours of which must relate to ethics, in
order to qualify for licensure as a public adjuster. The
continuing education must be in subjects designed to inform the
licensee regarding the current insurance laws of this state for
the purpose of enabling him or her to engage in business as an
insurance adjuster fairly and without injury to the public and
to adjust all claims in accordance with the insurance contract
and the laws of this state.

Section 11. Effective January 1, 2011, section 626.8796,
Florida Statutes, is amended to read:

626.8796 Public adjuster contracts; fraud statement.–

(1) All contracts for public adjuster services must be in
writing and must prominently display the following statement on
the contract: “Pursuant to s. 817.234, Florida Statutes, any
person who, with the intent to injure, defraud, or deceive any
insurer or insured, prepares, presents, or causes to be
presented a proof of loss or estimate of cost or repair of
damaged property in support of a claim under an insurance policy
knowing that the proof of loss or estimate of claim or repairs
contains any false, incomplete, or misleading information
concerning any fact or thing material to the claim commits a
felony of the third degree, punishable as provided in s.
775.082, s. 775.083, or s. 775.084, Florida Statutes.”

(2) A public adjuster contract must contain the following
information: full name, permanent business address, and license
number of the public adjuster, the full name of the public
adjusting firm, and the insured’s full name and street address,
together with a brief description of the loss. The contract must
state the percentage of compensation for the public adjuster’s
services, the type of claim, including an emergency claim,
nonemergency claim, or supplemental claim, the signatures of the
public adjuster and all named insureds, and the signature date.
If all named insureds signatures are not available, the public
adjuster shall submit an affidavit signed by the available named
insureds attesting that they have authority to enter into the
contract and to settle all claim issues on behalf of all named
insureds. An unaltered copy of the executed contract must be
remitted to the insurer within 30 days after execution.

Section 12. Effective June 1, 2010, section 626.70132,
Florida Statutes, is created to read:

626.70132 Duty to file windstorm or hurricane claim.—A
claim, supplemental claim, or reopened claim under an insurance
policy that provides personal lines residential coverage, as
defined in s. 627.4025, for loss or damage caused by the peril
of windstorm or hurricane is barred unless notice of the claim,
supplemental claim, or reopened claim was given to the insurer
in accordance with the terms of the policy within 3 years after
the hurricane first made landfall or the windstorm caused the covered damage. For purposes of this section, the term “supplemental claim” or “reopened claim” means any additional claim for recovery from the insurer for losses from the same hurricane or windstorm for which the insurer has previously adjusted pursuant to the initial claim. This section may not be interpreted to affect any applicable limitation on civil actions provided in s. 95.11 for claims, supplemental claims, or reopened claims timely filed under this section.

Section 13. Section 627.0613, Florida Statutes, is amended to read:

627.0613 Consumer advocate.—The Chief Financial Officer must appoint a consumer advocate who must represent the general public of the state before the department and the office. The consumer advocate must report directly to the Chief Financial Officer, but is not otherwise under the authority of the department or of any employee of the department. The consumer advocate has such powers as are necessary to carry out the duties of the office of consumer advocate, including, but not limited to, the powers to:

(1) Recommend to the department or office, by petition, the commencement of any proceeding or action; appear in any proceeding or action before the department or office; or appear in any proceeding before the Division of Administrative Hearings relating to subject matter under the jurisdiction of the department or office.

(2) Have access to and use of all files, records, and data of the department or office.

(3) Examine rate and form filings submitted to the office,
hire consultants as necessary to aid in the review process, and
recommend to the department or office any position deemed by the
consumer advocate to be in the public interest.

(4) By June 1, 2012, and each June 1 thereafter, prepare an
annual report card for each authorized personal residential
property insurer, on a form and using a letter-grade scale
developed by the commission by rule, which objectively grades
each insurer based on the following factors:

(a) The number and nature of valid consumer complaints, as
a market share ratio, received by the department against the
insurer.

(b) The disposition of all valid consumer complaints
received by the department.

(c) The average length of time for payment of claims by the
insurer.

(d) Any other measurable and objective factors the
commission identifies as capable of assisting policyholders in
making informed choices about homeowner’s insurance.

For purposes of this subsection, the term “valid consumer
complaint” means a written communication, or oral communication
that is subsequently converted to a written form, from a
consumer that expresses dissatisfaction involving a personal
residential insurance policy with a specific personal
residential property insurer. However, a valid complaint does
not arise if in the disposition thereof by the department the
insurer or agent position is upheld, the policy provision is
upheld, the coverage is explained, additional information is
provided, the complaint is withdrawn, the complaint is referred
outside the department, or if an inquiry has missing or
insufficient information, is not within the jurisdiction of the
department or requests mediation of a claim that is not eligible
for mediation.

(5) Prepare an annual budget for presentation to the
Legislature by the department, which budget must be adequate to
carry out the duties of the office of consumer advocate.

Section 14. Section 627.062, Florida Statutes, is amended
to read:

627.062 Rate standards.—

(1) The rates for all classes of insurance to which the
provisions of this part are applicable shall not be excessive, inad-
quate, or unfairly discriminatory.

(2) As to all such classes of insurance:

(a) Insurers or rating organizations shall establish and
use rates, rating schedules, or rating manuals to allow the
insurer a reasonable rate of return on such classes of insurance
written in this state. A copy of rates, rating schedules, rating
manuals, premium credits or discount schedules, and surcharge
schedules, and changes thereto, shall be filed with the office
under one of the following procedures except as provided in
subparagraph 3.:

1. If the filing is made at least 90 days before the
proposed effective date and the filing is not implemented during
the office’s review of the filing and any proceeding and
judicial review, then such filing shall be considered a “file
and use” filing. In such case, the office shall finalize its
review by issuance of an approval a notice of intent to approve
or a notice of intent to disapprove within 90 days after receipt
of the filing. The approval notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings shall not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue an approval a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.

2. If the filing is not made in accordance with the provisions of subparagraph 1., such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a “use and file” filing. An insurer making a “use and file” filing is potentially subject to an order by the office to return to policyholders portions of rates found to be excessive, as provided in paragraph (h).

3. For all property insurance filings made or submitted after January 25, 2007, but before December 31, 2010, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a “file and use” filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered to be property coverages.

(b) Upon receiving a rate filing, the office shall review the rate filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:
1. Past and prospective loss experience within and without this state.

2. Past and prospective expenses.

3. The degree of competition among insurers for the risk insured.

4. Investment income reasonably expected by the insurer, consistent with the insurer’s investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to such classes of insurance written in this state and the manner in which such investment income shall be used to calculate insurance rates. Such manner shall contemplate allowances for an underwriting profit factor and full consideration of investment income which produce a reasonable rate of return; however, investment income from invested surplus may not be considered.

5. The reasonableness of the judgment reflected in the filing.

6. Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.

7. The adequacy of loss reserves.

8. The cost of reinsurance. The office shall not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer’s estimated 250-year probable maximum loss or any lower level of loss.
9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

10. Conflagration and catastrophe hazards, if applicable.

11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.

12. A reasonable margin for underwriting profit and contingencies.

13. The cost of medical services, if applicable.

14. Other relevant factors which impact upon the frequency or severity of claims or upon expenses.

(c) In the case of fire insurance rates, consideration shall be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.

(d) If conflagration or catastrophe hazards are given consideration by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and shall maintain the premium in a catastrophe reserve. Any removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes shall be subject to approval of the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes shall be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in
paragraphs (b), (c), and (d), a rate may be found by the office

1. Rates shall be deemed excessive if they are likely to

produce a profit from Florida business that is unreasonably high

in relation to the risk involved in the class of business or if

expenses are unreasonably high in relation to services rendered.

2. Rates shall be deemed excessive if, among other things,

the rate structure established by a stock insurance company

provides for replenishment of surpluses from premiums, when the

replenishment is attributable to investment losses.

3. Rates shall be deemed inadequate if they are clearly

insufficient, together with the investment income attributable

to them, to sustain projected losses and expenses in the class

of business to which they apply.

4. A rating plan, including discounts, credits, or

surcharges, shall be deemed unfairly discriminatory if it fails

to clearly and equitably reflect consideration of the

policyholder’s participation in a risk management program

adopted pursuant to s. 627.0625.

5. A rate shall be deemed inadequate as to the premium

charged to a risk or group of risks if discounts or credits are

allowed which exceed a reasonable reflection of expense savings

and reasonably expected loss experience from the risk or group

of risks.

6. A rate shall be deemed unfairly discriminatory as to a

risk or group of risks if the application of premium discounts,

credits, or surcharges among such risks does not bear a

reasonable relationship to the expected loss and expense
experience among the various risks.

(f) In reviewing a rate filing, the office may require the insurer to provide at the insurer’s expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.

(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for a period of 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the office all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to the procedures of paragraph (a) within 90 days after receipt of the insurer’s initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the
office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office
withdraws the notification, the insurer shall not alter the rate except to conform with the office’s notice until the earlier of
120 days after the date the notification was provided or 180
days after the date of the implementation of the rate. The
office may, subject to chapter 120, disapprove without the 60-
day notification any rate increase filed by an insurer within
the prohibited time period or during the time that the legality
of the increased rate is being contested.

(h) If in the event the office finds that a rate or rate
change is excessive, inadequate, or unfairly discriminatory, the
office shall issue an order of disapproval specifying that a new
rate or rate schedule which responds to the findings of the
office be filed by the insurer. The office shall further order,
for any “use and file” filing made in accordance with
subparagraph (a)2., that premiums charged each policyholder
constituting the portion of the rate above that which was
actuarially justified be returned to such policyholder in the
form of a credit or refund. If the office finds that an
insurer’s rate or rate change is inadequate, the new rate or
rate schedule filed with the office in response to such a
finding shall be applicable only to new or renewal business of
the insurer written on or after the effective date of the
responsive filing.

(i)1. Except as otherwise specifically provided in this
chapter, the office shall not, directly or indirectly, prohibit
any insurer, including any residual market plan or joint
underwriting association, from paying acquisition costs based on
the full amount of premium, as defined in s. 627.403, applicable
to any policy, or directly or indirectly prohibit any such
insurer from including the full amount of acquisition costs in a
rate filing.

2. The office shall not, directly or indirectly, impede,
abridge, or otherwise compromise an insurer’s right to acquire
policyholders, advertise, or appoint agents, including the
calculation, manner, or amount of such agent commissions, if
any.

(j) With respect to residential property insurance rate
filings, the rate filing must account for mitigation measures
undertaken by policyholders to reduce hurricane losses.

(k)1.a. An insurer may make a separate filing limited
solely to an adjustment of its rates for reinsurance, the cost
of financing products used as a replacement for reinsurance, or
financing costs incurred in the purchase of reinsurance, and an
inflation trend factor published by the office pursuant to
subparagraph 4. If an insurer chooses to make a separate filing
under this paragraph, it must implement the rate in such a
manner that all rate increases implemented as a result of the
separate filing, together with rate increases associated with
any other rate filing, do or financing products to replace or
finance the payment of the amount covered by the Temporary
Increase in Coverage Limits (TICL) portion of the Florida
Hurricane Catastrophe Fund including replacement reinsurance for
the TICL reductions made pursuant to s. 215.555(17)(e); the
actual cost paid due to the application of the TICL premium
factor pursuant to s. 215.555(17)(f); and the actual cost paid
due to the application of the cash build-up factor pursuant to
s. 215.555(5)(b) if the insurer:
   a. Elects to purchase financing products such as a liquidity instrument or line of credit, in which case the cost included in the filing for the liquidity instrument or line of credit may not result in a premium increase exceeding 3 percent for any individual policyholder. All costs contained in the filing may not result in an overall premium increase of more than 10 percent for any individual policyholder, excluding coverage changes and surcharges, within the same policy year.
   b. An insurer that makes a filing relating to reinsurance or financing products must include the following in the filing: a copy of all of its reinsurance, liquidity instrument, or line of credit contracts; proof of the billing or payment for the contracts; and the calculation upon which the proposed rate change is based demonstrating that the costs meet the criteria of this section and are not loaded for expenses or profit for the insurer making the filing.
   c. Any filing made pursuant this paragraph may include only the changes to its rates which are expressly authorized by this paragraph in the filing.
   d. Has not implemented a rate increase within the 6 months immediately preceding the filing.
   e. Does not file for a rate increase under any other paragraph within 6 months after making a filing under this paragraph.
   d. f. An insurer that purchases reinsurance or financing products from an affiliated company may make a filing pursuant to in compliance with this paragraph does so only if the costs for such reinsurance or financing products are charged at or
below charges made for comparable coverage by nonaffiliated reinsurers or financial entities making such coverage or financing products available in this state.

e. An insurer that makes a filing as the result of a change in an inflation trend factor published by the office need support that filing only with rates and rating examples and an explanation demonstrating the insurer’s eligibility to adopt the inflation trend factor.

2. An insurer may only make only one filing in any 12-month period under this paragraph.

3. An insurer that elects to implement a rate change under this paragraph must file its rate filing with the office at least 45 days before the effective date of the rate change. After an insurer submits a complete filing that meets all of the requirements of this paragraph, the office has 45 days after the date of the filing to review the rate filing and determine if the rate is excessive, inadequate, or unfairly discriminatory.

4. Beginning January 1, 2011, the office shall publish an annual informational memorandum to establish one or more inflation trend factors that may be stated separately for personal and residential property and for building coverage, contents coverage, additional living expense coverage, and liability coverage, if applicable. These factors shall represent an estimate of cost increases or decreases based upon publicly available relevant data and economic indices that are identified in the memorandum. Such factors are exempt from the rulemaking requirements of chapter 120, and insurers are not required to adopt the factors. The office may publish factors for any line of insurance, but is required to publish a factor only for
residential property insurance.

The provisions of this subsection shall not apply to workers’ compensation and employer’s liability insurance and to motor vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer’s rates, rating schedules, rating manuals, and underwriting rules filed with the office and which have been submitted to the insurer for individual rating, the insurer must maintain documentation on each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for a period of at least 5 years after the effective date of the policy.

(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.

(c) This subsection does not apply to private passenger motor vehicle insurance.

(4)(a) Contingent on specific appropriations made to implement this subsection, in order to enhance the ability of consumers to compare premiums and to increase the accuracy and
usefulness of rate and product comparison information for
homeowners’ insurance, the office shall develop or contract with
a private entity to develop a comprehensive program for
providing the consumer with all available information necessary
to make an informed purchase of the insurance product that best
serves the needs of the individual.

(b) In developing the comprehensive program, the office
shall rely as much as is practical on information that is
currently available and shall consider:

1. The most efficient means for developing, hosting, and
operating a separate website that consolidates all consumer
information for price comparisons, filed complaints, financial
strength, underwriting, and receivership information and other
data useful to consumers;

2. Whether all admitted insurers should be required to
submit additional information to populate the composite website
and how often such submissions must be made;

3. Whether all admitted insurers should be required to
provide links from the website into each individual insurer’s
website in order to enable consumers to access product rate
information and apply for quotations;

4. Developing a plan to publicize the existence,
availability, and value of the website; and

5. Any other provision that would make relevant homeowners’
insurance information more readily available so that consumers
can make informed product comparisons and purchasing decisions.

(c) Before establishing the program or website, the office
shall conduct a cost-benefit analysis to determine the most
effective approach for establishing and operating the program
and website. Based on the results of the analysis, the office shall submit a proposed implementation plan for review and approval by the Financial Services Commission. The implementation plan shall include an estimated timeline for establishing the program and website; a description of the data and functionality to be provided by the site; a strategy for publicizing the website to consumers; a recommended approach for developing, hosting, and operating the website; and an estimate of all major nonrecurring and recurring costs required to establish and operate the website. Upon approval of the plan, the office may initiate the establishment of the program.

(5) The establishment of any rate, rating classification, rating plan or schedule, or variation thereof in violation of part IX of chapter 626 is also in violation of this section. In order to enhance the ability of consumers to compare premiums and to increase the accuracy and usefulness of rate-comparison information provided by the office to the public, the office shall develop a proposed standard rating territory plan to be used by all authorized property and casualty insurers for residential property insurance. In adopting the proposed plan, the office may consider geographical characteristics relevant to risk, county lines, major roadways, existing rating territories used by a significant segment of the market, and other relevant factors. Such plan shall be submitted to the President of the Senate and the Speaker of the House of Representatives by January 15, 2006. The plan may not be implemented unless authorized by further act of the Legislature.

(6) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a
reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the Florida Hurricane Catastrophe Fund, together with reasonable costs of other reinsurance, but except as otherwise provided in this section, may not recoup reinsurance costs that duplicate coverage provided by the Florida Hurricane Catastrophe Fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year’s reimbursement premium, and any over-recoupment shall be subtracted from the following year’s reimbursement premium.

(7)(6)(a) If an insurer requests an administrative hearing pursuant to s. 120.57 related to a rate filing under this section, the director of the Division of Administrative Hearings shall expedite the hearing and assign an administrative law judge who shall commence the hearing within 30 days after the receipt of the formal request and shall enter a recommended order within 30 days after the hearing or within 30 days after receipt of the hearing transcript by the administrative law judge, whichever is later. Each party shall be allowed 10 days in which to submit written exceptions to the recommended order. The office shall enter a final order within 30 days after the entry of the recommended order. The provisions of this paragraph may be waived upon stipulation of all parties.

(b) Upon entry of a final order, the insurer may request a expedited appellate review pursuant to the Florida Rules of Appellate Procedure. It is the intent of the Legislature that the First District Court of Appeal grant an insurer’s request
for an expedited appellate review.

(8)(7) (a) The provisions of this subsection apply only with respect to rates for medical malpractice insurance and shall control to the extent of any conflict with other provisions of this section.

(b) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer’s rate base, and shall not be used to justify a rate or rate change.

Any common-law bad faith action identified as such, any portion of a settlement entered as a result of a statutory or common-law action, or any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney’s fees which is identified as being related to the bad faith and punitive damages in these judgments and settlements may not be included in the insurer’s rate base and may not be used to justify a rate or rate change.

(c) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, either using loss experience solely for this state or giving greater credibility to this state’s loss data after applying actuarially sound methods of assigning credibility to such data.

(d) Rates shall be deemed excessive if, among other standards established by this section, the rate structure
provides for replenishment of reserves or surpluses from
premiums when the replenishment is attributable to investment
losses.

(e) The insurer must apply a discount or surcharge based on
the health care provider’s loss experience or shall establish an
alternative method giving due consideration to the provider’s
loss experience. The insurer must include in the filing a copy
of the surcharge or discount schedule or a description of the
alternative method used, and must provide a copy of such
schedule or description, as approved by the office, to
policyholders at the time of renewal and to prospective
policyholders at the time of application for coverage.

(f) Each medical malpractice insurer must make a rate
filing under this section, sworn to by at least two executive
officers of the insurer, at least once each calendar year.

(8)(a)1. No later than 60 days after the effective date of
medical malpractice legislation enacted during the 2003 Special
Session D of the Florida Legislature, the office shall calculate
a presumed factor that reflects the impact that the changes
contained in such legislation will have on rates for medical
malpractice insurance and shall issue a notice informing all
insurers writing medical malpractice coverage of such presumed
factor. In determining the presumed factor, the office shall use
generally accepted actuarial techniques and standards provided
in this section in determining the expected impact on losses,
expenses, and investment income of the insurer. To the extent
that the operation of a provision of medical malpractice
legislation enacted during the 2003 Special Session D of the
Florida Legislature is stayed pending a constitutional
challenge, the impact of that provision shall not be included in
the calculation of a presumed factor under this subparagraph.

2. No later than 60 days after the office issues its notice
of the presumed rate change factor under subparagraph 1., each
insurer writing medical malpractice coverage in this state shall
submit to the office a rate filing for medical malpractice
insurance, which will take effect no later than January 1, 2004,
and apply retroactively to policies issued or renewed on or
after the effective date of medical malpractice legislation
enacted during the 2003 Special Session D of the Florida
Legislature. Except as authorized under paragraph (b), the
filing shall reflect an overall rate reduction at least as great
as the presumed factor determined under subparagraph 1. With
respect to policies issued on or after the effective date of
such legislation and prior to the effective date of the rate
filing required by this subsection, the office shall order the
insurer to make a refund of the amount that was charged in
excess of the rate that is approved.

(b) Any insurer or rating organization that contends that
the rate provided for in paragraph (a) is excessive, inadequate,
or unfairly discriminatory shall separately state in its filing
the rate it contends is appropriate and shall state with
specificity the factors or data that it contends should be
considered in order to produce such appropriate rate. The
insurer or rating organization shall be permitted to use all of
the generally accepted actuarial techniques provided in this
section in making any filing pursuant to this subsection. The
office shall review each such exception and approve or
disapprove it prior to use. It shall be the insurer’s burden to
actuarially justify any deviations from the rates required to be filed under paragraph (a). The insurer making a filing under this paragraph shall include in the filing the expected impact of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature on losses, expenses, and rates.

(c) If any provision of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature is held invalid by a court of competent jurisdiction, the office shall permit an adjustment of all medical malpractice rates filed under this section to reflect the impact of such holding on such rates so as to ensure that the rates are not excessive, inadequate, or unfairly discriminatory.

(d) Rates approved on or before July 1, 2003, for medical malpractice insurance shall remain in effect until the effective date of a new rate filing approved under this subsection.

(e) The calculation and notice by the office of the presumed factor pursuant to paragraph (a) is not an order or rule that is subject to chapter 120. If the office enters into a contract with an independent consultant to assist the office in calculating the presumed factor, such contract shall not be subject to the competitive solicitation requirements of s. 287.057.

(9) (a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a rate filing:

CODING: Words stricken are deletions; words underlined are additions.
1. The signing officer and actuary have reviewed the rate filing;

2. Based on the signing officer’s and actuary’s knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading;

3. Based on the signing officer’s and actuary’s knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and

4. Based on the signing officer’s and actuary’s knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.

(b) A signing officer or actuary knowingly making a false certification under this subsection commits a violation of s. 626.9541(1)(e) and is subject to the penalties under s. 626.9521.

(c) Failure to provide such certification by the officer and actuary shall result in the rate filing being disapproved without prejudice to be refiled.

(d) A certification made pursuant to paragraph (a) is not rendered false if, after making the subject rate filing, the insurer provides the office with additional or supplementary information pursuant to a formal or informal request from the office.
(e)(e) The commission may adopt rules and forms pursuant to ss. 120.536(1) and 120.54 to administer this subsection.

(10) The burden is on the office to establish that rates are excessive for personal lines residential coverage with a dwelling replacement cost of $1 million or more or for a single condominium unit with a combined dwelling and contents replacement cost of $1 million or more. Upon request of the office, the insurer shall provide to the office such loss and expense information as the office reasonably needs to meet this burden.

(11) Any interest paid pursuant to s. 627.70131(5) may not be included in the insurer’s rate base and may not be used to justify a rate or rate change.

Section 15. Section 627.0629, Florida Statutes, is amended to read:

627.0629 Residential property insurance; rate filings.—

(1) (a) It is the intent of the Legislature that insurers must provide the most accurate pricing signals available savings to encourage consumers to who install or implement windstorm damage mitigation techniques, alterations, or solutions to their properties to prevent windstorm losses. It is also the intent of the Legislature that implementation of mitigation discounts not result in a loss of income to the insurers granting the discounts, so that the aggregate of mitigation discounts should not exceed the aggregate of the expected reduction in loss that is attributable to the mitigation efforts for which discounts are granted. A rate filing for residential property insurance must include actuarially reasonable discounts, credits, debits, or other rate differentials, or appropriate reductions in
deductibles, which provide the proper pricing for all properties. The rate filing must take into account the presence or absence of fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. The fixtures or construction techniques shall include, but not be limited to, fixtures or construction techniques that enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength. Credits, debits, discounts, or other rate differentials, or appropriate reductions or increases in deductibles, which recognize the presence or absence of fixtures and construction techniques that meet the minimum requirements of the Florida Building Code must be included in the rate filing. If an insurer demonstrates that the aggregate of its mitigation discounts results in a reduction to revenue which exceeds the reduction of the aggregate loss that is expected to result from the mitigation, that insurer may recover the lost revenue through an increase in its base rates. All insurance companies must make a rate filing which includes the credits, discounts, or other rate differentials or reductions in deductibles by February 28, 2003. By July 1, 2007, the office shall reevaluate the discounts, credits, other rate differentials, and appropriate reductions in deductibles for fixtures and construction techniques that meet the minimum requirements of the Florida Building Code, based upon actual experience or any other loss relativity studies available to the office. The office shall determine the discounts, credits, debits, other rate differentials, and appropriate reductions or
increases in deductibles that reflect the full actuarial value of such revaluation, which may be used by insurers in rate filings.

(b) By February 1, 2011, the Office of Insurance Regulation, in consultation with the Department of Financial Services and the Department of Community Affairs, shall develop and make publicly available a proposed method for insurers to establish discounts, credits, or other rate differentials for hurricane mitigation measures which directly correlate to the numerical rating assigned to a structure pursuant to the uniform home grading scale adopted by the Financial Services Commission pursuant to s. 215.55865, including any proposed changes to the uniform home grading scale. By October 1, 2011, the commission shall adopt rules requiring insurers to make rate filings for residential property insurance which revise insurers’ discounts, credits, or other rate differentials for hurricane mitigation measures so that such rate differentials correlate directly to the uniform home grading scale. The rules may include such changes to the uniform home grading scale as the commission determines are necessary, and may specify the minimum required discounts, credits, or other rate differentials. Such rate differentials must be consistent with generally accepted actuarial principles and wind-loss mitigation studies. The rules shall allow a period of at least 2 years after the effective date of the revised mitigation discounts, credits, or other rate differentials for a property owner to obtain an inspection or otherwise qualify for the revised credit, during which time the insurer shall continue to apply the mitigation credit that was applied immediately prior to the effective date of the revised
credit. Discounts, credits, and other rate differentials established for rate filings under this paragraph shall supersede, after adoption, the discounts, credits, and other rate differentials included in rate filings under paragraph (a).

(2)(a) A rate filing for residential property insurance made on or before the implementation of paragraph (b) may include rate factors that reflect the manner in which building code enforcement in a particular jurisdiction addresses the risk of wind damage. However, such a rate filing must also provide for variations from such rate factors on an individual basis based on an inspection of a particular structure by a licensed home inspector, which inspection may be at the cost of the insured.

(b) A rate filing for residential property insurance made more than 150 days after approval by the office of a building code rating factor plan submitted by a statewide rating organization shall include positive and negative rate factors that reflect the manner in which building code enforcement in a particular jurisdiction addresses risk of wind damage. The rate filing shall include variations from standard rate factors on an individual basis based on inspection of a particular structure by a licensed home inspector. If an inspection is requested by the insured, the insurer may require the insured to pay the reasonable cost of the inspection. This paragraph applies to structures constructed or renovated after the implementation of this paragraph.

(c) The premium notice shall specify the amount by which the rate has been adjusted as a result of this subsection and shall also specify the maximum possible positive and negative
adjustments that are approved for use by the insurer under this subsection.

(3) A rate filing made on or after July 1, 1995, for mobile home owner’s insurance must include appropriate discounts, credits, or other rate differentials for mobile homes constructed to comply with American Society of Civil Engineers Standard ANSI/ASCE 7-88, adopted by the United States Department of Housing and Urban Development on July 13, 1994, and that also comply with all applicable tie-down requirements provided by state law.

(4) The Legislature finds that separate consideration and notice of hurricane insurance premiums will assist consumers by providing greater assurance that hurricane premiums are lawful and by providing more complete information regarding the components of property insurance premiums. Effective January 1, 1997, a rate filing for residential property insurance shall be separated into two components, rates for hurricane coverage and rates for all other coverages. A premium notice reflecting a rate implemented on the basis of such a filing shall separately indicate the premium for hurricane coverage and the premium for all other coverages.

(5) In order to provide an appropriate transition period, an insurer may, in its sole discretion, implement an approved rate filing for residential property insurance over a period of years. An insurer electing to phase in its rate filing must provide an informational notice to the office setting out its schedule for implementation of the phased-in rate filing. An insurer may include in its rate the actual cost of private market reinsurance that corresponds to available coverage of the
Temporary Increase in Coverage Limits, TICL, from the Florida Hurricane Catastrophe Fund. The insurer may also include the cost of reinsurance to replace the TICL reduction implemented pursuant to s. 215.555(17)(d)9. However, this cost for reinsurance may not include any expense or profit load or result in a total annual base rate increase in excess of 10 percent.

(6) Any rate filing that is based in whole or part on data from a computer model may not exceed 15 percent unless there is a public hearing.

(7) An insurer may implement appropriate discounts or other rate differentials of up to 10 percent of the annual premium to mobile home owners who provide to the insurer evidence of a current inspection of tie-downs for the mobile home, certifying that the tie-downs have been properly installed and are in good condition.

(8) EVALUATION OF RESIDENTIAL PROPERTY STRUCTURAL SOUNDNESS.—

(a) It is the intent of the Legislature to provide a program whereby homeowners may obtain an evaluation of the wind resistance of their homes with respect to preventing damage from hurricanes, together with a recommendation of reasonable steps that may be taken to upgrade their homes to better withstand hurricane force winds.

(b) To the extent that funds are provided for this purpose in the General Appropriations Act, the Legislature hereby authorizes the establishment of a program to be administered by the Citizens Property Insurance Corporation for homeowners insured in the high-risk account.

(c) The program shall provide grants to homeowners, for the
purpose of providing homeowner applicants with funds to conduct
an evaluation of the integrity of their homes with respect to
withstanding hurricane force winds, recommendations to retrofit
the homes to better withstand damage from such winds, and the
estimated cost to make the recommended retrofits.

(d) The Department of Community Affairs shall establish by
rule standards to govern the quality of the evaluation, the
quality of the recommendations for retrofitting, the eligibility
of the persons conducting the evaluation, and the selection of
applicants under the program. In establishing the rule, the
Department of Community Affairs shall consult with the advisory
committee to minimize the possibility of fraud or abuse in the
evaluation and retrofitting process, and to ensure that funds
spent by homeowners acting on the recommendations achieve
positive results.

(e) The Citizens Property Insurance Corporation shall
identify areas of this state with the greatest wind risk to
residential properties and recommend annually to the Department
of Community Affairs priority target areas for such evaluations
and inclusion with the associated residential construction
mitigation program.

(9) A property insurance rate filing that includes any
adjustments related to premiums paid to the Florida Hurricane
Catastrophe Fund must include a complete calculation of the
insurer’s catastrophe load, and the information in the filing
may not be limited solely to recovery of moneys paid to the
fund.

Section 16. Paragraphs (b), (c), (d), and (y) of subsection
(6) of section 627.351, Florida Statutes, are amended to read:

CODING: Words stricken are deletions; words underlined are additions.
627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(b)1. All insurers authorized to write one or more subject lines of business in this state are subject to assessment by the corporation and, for the purposes of this subsection, are referred to collectively as “assessable insurers.” Insurers writing one or more subject lines of business in this state pursuant to part VIII of chapter 626 are not assessable insurers, but insurers who procure one or more subject lines of business in this state pursuant to part VIII of chapter 626 are subject to assessment by the corporation and are referred to collectively as “assessable insureds.” An authorized insurer’s assessment liability begins shall begin on the first day of the calendar year following the year in which the insurer was issued a certificate of authority to transact insurance for subject lines of business in this state and terminates shall terminate 1 year after the end of the first calendar year during which the insurer no longer holds a certificate of authority to transact insurance for subject lines of business in this state.

2.a. All revenues, assets, liabilities, losses, and expenses of the corporation are shall be divided into three separate accounts as follows:

(I) A personal lines account for personal residential policies issued by the corporation or issued by the Residential Property and Casualty Joint Underwriting Association and renewed by the corporation which provides that provide comprehensive, multiperil coverage on risks that are not located in areas eligible for coverage in the Florida Windstorm Underwriting Association as those areas were defined on January 1, 2002, and
for such policies that do not provide coverage for the peril of wind on risks that are located in such areas;

   (II) A commercial lines account for commercial residential and commercial nonresidential policies issued by the corporation or issued by the Residential Property and Casualty Joint Underwriting Association and renewed by the corporation which provide coverage for basic property perils on risks which are not located in areas eligible for coverage in the Florida Windstorm Underwriting Association as those areas were defined on January 1, 2002, and for such policies that do not provide coverage for the peril of wind on risks that are located in such areas; and

   (III) A coastal high-risk account for personal residential policies and commercial residential and commercial nonresidential property policies issued by the corporation or transferred to the corporation which provide coverage for the peril of wind on risks that are located in areas eligible for coverage in the Florida Windstorm Underwriting Association as those areas were defined on January 1, 2002. The corporation may offer policies that provide multiperil coverage and the corporation shall continue to offer policies that provide coverage only for the peril of wind for risks located in areas eligible for coverage in the coastal high-risk account. In issuing multiperil coverage, the corporation may use its approved policy forms and rates for the personal lines account. An applicant or insured who is eligible to purchase a multiperil policy from the corporation may purchase a multiperil policy from an authorized insurer without prejudice to the applicant’s or insured’s eligibility to
prospectively purchase a policy that provides coverage only for the peril of wind from the corporation. An applicant or insured who is eligible for a corporation policy that provides coverage only for the peril of wind may elect to purchase or retain such policy and also purchase or retain coverage excluding wind from an authorized insurer without prejudice to the applicant’s or insured’s eligibility to prospectively purchase a policy that provides multiperil coverage from the corporation. It is the goal of the Legislature that there would be an overall average savings of 10 percent or more for a policyholder who currently has a wind-only policy with the corporation, and an ex-wind policy with a voluntary insurer or the corporation, and who then obtains a multiperil policy from the corporation. It is the intent of the Legislature that the offer of multiperil coverage in the coastal high-risk account be made and implemented in a manner that does not adversely affect the tax-exempt status of the corporation or creditworthiness of or security for currently outstanding financing obligations or credit facilities of the coastal high-risk account, the personal lines account, or the commercial lines account. The coastal high-risk account must also include quota share primary insurance under subparagraph (c)2. The area eligible for coverage under the coastal high-risk account also includes the area within Port Canaveral, which is bordered on the south by the City of Cape Canaveral, bordered on the west by the Banana River, and bordered on the north by Federal Government property.

b. The three separate accounts must be maintained as long as financing obligations entered into by the Florida Windstorm Underwriting Association or Residential Property and Casualty
Joint Underwriting Association are outstanding, in accordance with the terms of the corresponding financing documents. If the financing obligations are no longer outstanding in accordance with the terms of the corresponding financing documents, the corporation may use a single account for all revenues, assets, liabilities, losses, and expenses of the corporation. Consistent with the requirement of this subparagraph and prudent investment policies that minimize the cost of carrying debt, the board shall exercise its best efforts to retire existing debt or to obtain approval of necessary parties to amend the terms of existing debt, so as to structure the most efficient plan to consolidate the three separate accounts into a single account. By February 1, 2007, the board shall submit a report to the Financial Services Commission, the President of the Senate, and the Speaker of the House of Representatives which includes an analysis of consolidating the accounts, the actions the board has taken to minimize the cost of carrying debt, and its recommendations for executing the most efficient plan.

c. Creditors of the Residential Property and Casualty Joint Underwriting Association and of the accounts specified in sub-sub-subparagraphs a.(I) and (II) may have a claim against, and recourse to, the accounts referred to in sub-sub-subparagraphs a.(I) and (II) and shall have no claim against, or recourse to, the account referred to in sub-sub-subparagraph a.(III). Creditors of the Florida Windstorm Underwriting Association shall have a claim against, and recourse to, the account referred to in sub-sub-subparagraph a.(III) and shall have no claim against, or recourse to, the accounts referred to in sub-paragraphs a.(I) and (II).
d. Revenues, assets, liabilities, losses, and expenses not attributable to particular accounts shall be prorated among the accounts.

e. The Legislature finds that the revenues of the corporation are revenues that are necessary to meet the requirements set forth in documents authorizing the issuance of bonds under this subsection.

f. No part of the income of the corporation may inure to the benefit of any private person.

3. With respect to a deficit in an account:

a. After accounting for the Citizens policyholder surcharge imposed under sub-subparagraph i., if when the remaining projected deficit incurred in a particular calendar year is not greater than 6 percent of the aggregate statewide direct written premium for the subject lines of business for the prior calendar year, the entire deficit shall be recovered through regular assessments of assessable insurers under paragraph (p) and assessable insureds.

b. After accounting for the Citizens policyholder surcharge imposed under sub-subparagraph i., when the remaining projected deficit incurred in a particular calendar year exceeds 6 percent of the aggregate statewide direct written premium for the subject lines of business for the prior calendar year, the corporation shall levy regular assessments on assessable insurers under paragraph (q) and on assessable insureds in an amount equal to the greater of 6 percent of the deficit or 6 percent of the aggregate statewide direct written premium for the subject lines of business for the prior calendar year. Any
remaining deficit shall be recovered through emergency
assessments under sub-subparagraph d.

c. Each assessable insurer’s share of the amount being
assessed under sub-subparagraph a. or sub-subparagraph b. **must**
shall be in the proportion that the assessable insurer’s direct
written premium for the subject lines of business for the year
preceding the assessment bears to the aggregate statewide direct
written premium for the subject lines of business for that year. The assessment percentage applicable to each assessable insured
is the ratio of the amount being assessed under sub-subparagraph
a. or sub-subparagraph b. to the aggregate statewide direct
written premium for the subject lines of business for the prior
year. Assessments levied by the corporation on assessable
insurers under sub-subparagraphs a. and b. shall be paid as
required by the corporation’s plan of operation and paragraph
(q) **(p)**. Assessments levied by the corporation on assessable
insureds under sub-subparagraphs a. and b. shall be collected by
the surplus lines agent at the time the surplus lines agent
collects the surplus lines tax required by s. 626.932 and **shall**
be paid to the Florida Surplus Lines Service Office at the time
the surplus lines agent pays the surplus lines tax to the
Florida Surplus Lines Service Office. Upon receipt of regular
assessments from surplus lines agents, the Florida Surplus Lines
Service Office shall transfer the assessments directly to the
corporation as determined by the corporation.

d. Upon a determination by the board of governors that a
deficit in an account exceeds the amount that will be recovered
through regular assessments under sub-subparagraph a. or sub-
subparagraph b., plus the amount that is expected to be
recovered through surcharges under sub-subparagraph i., as to
the remaining projected deficit, the board shall levy, after
verification by the office, emergency assessments, for as many
years as necessary to cover the deficits, to be collected by
assessable insurers and the corporation and collected from
assessable insureds upon issuance or renewal of policies for
subject lines of business, excluding National Flood Insurance
policies. The amount of the emergency assessment collected in a
particular year shall be a uniform percentage of that year’s
direct written premium for subject lines of business and all
direct accounts of the corporation, excluding National Flood Insurance
Program policy premiums, as annually determined by the board and
verified by the office. The office shall verify the arithmetic
calculations involved in the board’s determination within 30
days after receipt of the information on which the determination
was based. Notwithstanding any other provision of law, the
corporation and each assessable insurer that writes subject
lines of business shall collect emergency assessments from its
policyholders without such obligation being affected by any
credit, limitation, exemption, or deferment. Emergency
assessments levied by the corporation on assessable insureds
shall be collected by the surplus lines agent at the time the
surplus lines agent collects the surplus lines tax required by
s. 626.932 and shall be paid to the Florida Surplus Lines
Service Office at the time the surplus lines agent pays the
surplus lines tax to the Florida Surplus Lines Service Office.
The emergency assessments so collected shall be transferred
directly to the corporation on a periodic basis as determined by
the corporation and shall be held by the corporation solely in
the applicable account. The aggregate amount of emergency assessments levied for an account under this sub-subparagraph in any calendar year may, at the discretion of the board of governors, be less than but may not exceed the greater of 10 percent of the amount needed to cover the deficit, plus interest, fees, commissions, required reserves, and other costs associated with financing of the original deficit, or 10 percent of the aggregate statewide direct written premium for subject lines of business and for all accounts of the corporation for the prior year, plus interest, fees, commissions, required reserves, and other costs associated with financing the deficit. 

   e. The corporation may pledge the proceeds of assessments, projected recoveries from the Florida Hurricane Catastrophe Fund, other insurance and reinsurance recoverables, policyholder surcharges and other surcharges, and other funds available to the corporation as the source of revenue for and to secure bonds issued under paragraph (p), bonds or other indebtedness issued under subparagraph (c)3., or lines of credit or other financing mechanisms issued or created under this subsection, or to retire any other debt incurred as a result of deficits or events giving rise to deficits, or in any other way that the board determines will efficiently recover such deficits. The purpose of the lines of credit or other financing mechanisms is to provide additional resources to assist the corporation in covering claims and expenses attributable to a catastrophe. As used in this subsection, the term “assessments” includes regular assessments under sub-subparagraph a., sub-subparagraph b., or subparagraph (p)1. and emergency assessments under sub-subparagraph d. 

Emergency assessments collected under sub-subparagraph d. are
not part of an insurer’s rates, are not premium, and are not subject to premium tax, fees, or commissions; however, failure to pay the emergency assessment shall be treated as failure to pay premium. The emergency assessments under sub-subparagraph d. shall continue as long as any bonds issued or other indebtedness incurred with respect to a deficit for which the assessment was imposed remain outstanding, unless adequate provision has been made for the payment of such bonds or other indebtedness pursuant to the documents governing such bonds or other indebtedness.

f. As used in this subsection for purposes of any deficit incurred on or after January 25, 2007, the term “subject lines of business” means insurance written by assessable insurers or procured by assessable insureds for all property and casualty lines of business in this state, but not including workers’ compensation or medical malpractice. As used in the sub-subparagraph, the term “property and casualty lines of business” includes all lines of business identified on Form 2, Exhibit of Premiums and Losses, in the annual statement required of authorized insurers by s. 624.424 and any rule adopted under this section, except for those lines identified as accident and health insurance and except for policies written under the National Flood Insurance Program or the Federal Crop Insurance Program. For purposes of this sub-subparagraph, the term “workers’ compensation” includes both workers’ compensation insurance and excess workers’ compensation insurance.

g. The Florida Surplus Lines Service Office shall determine annually the aggregate statewide written premium in subject lines of business procured by assessable insureds and shall
report that information to the corporation in a form and at a time the corporation specifies to ensure that the corporation can meet the requirements of this subsection and the corporation’s financing obligations.

h. The Florida Surplus Lines Service Office shall verify the proper application by surplus lines agents of assessment percentages for regular assessments and emergency assessments levied under this subparagraph on assessable insureds and shall assist the corporation in ensuring the accurate, timely collection and payment of assessments by surplus lines agents as required by the corporation.

i. (I) If a deficit is incurred in any account in 2008 or thereafter, the board of governors shall levy a Citizens policyholder surcharge against all policyholders of the corporation for a 12-month period, which

(II) The Citizens policyholder surcharge shall be levied collected at the time of issuance or renewal of a policy, as a uniform percentage of the premium for the policy of up to 15 percent of such premium, which funds shall be used to offset the deficit.

(III) The Citizens policyholder surcharge is payable upon cancellation or termination of the policy, upon renewal of the policy, or upon issuance of a new policy by Citizens within the first 12 months after the date of the levy or the period of time necessary to fully collect the Citizens policyholder surcharge amount.

(IV) The corporation may not levy any regular assessments under paragraph (q) pursuant to sub-subparagraph a. or sub-subparagraph b. with respect to a particular year’s deficit.
until the corporation has first levied a Citizens policyholder surcharge under this sub-subparagraph in the full amount authorized by this sub-subparagraph.

(V) Citizens policyholder surcharges under this sub-subparagraph are not considered premium and are not subject to commissions, fees, or premium taxes. However, failure to pay such surcharges shall be treated as failure to pay premium.

j. If the amount of any assessments or surcharges collected from corporation policyholders, assessable insurers or their policyholders, or assessable insureds exceeds the amount of the deficits, such excess amounts shall be remitted to and retained by the corporation in a reserve to be used by the corporation, as determined by the board of governors and approved by the office, to pay claims or reduce any past, present, or future plan-year deficits or to reduce outstanding debt.

(c) The plan of operation of the corporation:

1. Must provide for adoption of residential property and casualty insurance policy forms and commercial residential and nonresidential property insurance forms, which forms must be approved by the office prior to use. The corporation shall adopt the following policy forms:

a. Standard personal lines policy forms that are comprehensive multiperil policies providing full coverage of a residential property equivalent to the coverage provided in the private insurance market under an HO-3, HO-4, or HO-6 policy.

b. Basic personal lines policy forms that are policies similar to an HO-8 policy or a dwelling fire policy that provide coverage meeting the requirements of the secondary mortgage market, but which coverage is more limited than the coverage
under a standard policy.

c. Commercial lines residential and nonresidential policy forms that are generally similar to the basic perils of full coverage obtainable for commercial residential structures and commercial nonresidential structures in the admitted voluntary market.

d. Personal lines and commercial lines residential property insurance forms that cover the peril of wind only. The forms are applicable only to residential properties located in areas eligible for coverage under the coastal high-risk account referred to in sub-subparagraph (b)2.a.

e. Commercial lines nonresidential property insurance forms that cover the peril of wind only. The forms are applicable only to nonresidential properties located in areas eligible for coverage under the coastal high-risk account referred to in sub-subparagraph (b)2.a.

f. The corporation may adopt variations of the policy forms listed in sub-subparagraphs a.-e. that contain more restrictive coverage.

2.a. Must provide that the corporation adopt a program in which the corporation and authorized insurers enter into quota share primary insurance agreements for hurricane coverage, as defined in s. 627.4025(2)(a), for eligible risks, and adopt property insurance forms for eligible risks which cover the peril of wind only. As used in this subsection, the term:

(I) “Quota share primary insurance” means an arrangement in which the primary hurricane coverage of an eligible risk is provided in specified percentages by the corporation and an authorized insurer. The corporation and authorized insurer are
each solely responsible for a specified percentage of hurricane
coverage of an eligible risk as set forth in a quota share
primary insurance agreement between the corporation and an
authorized insurer and the insurance contract. The
responsibility of the corporation or authorized insurer to pay
its specified percentage of hurricane losses of an eligible
risk, as set forth in the quota share primary insurance
agreement, may not be altered by the inability of the other
party to the agreement to pay its specified percentage of
hurricane losses. Eligible risks that are provided hurricane
coverage through a quota share primary insurance arrangement
must be provided policy forms that set forth the obligations of
the corporation and authorized insurer under the arrangement,
clearly specify the percentages of quota share primary insurance
provided by the corporation and authorized insurer, and
conspicuously and clearly state that neither the authorized
insurer nor the corporation may be held responsible beyond its
specified percentage of coverage of hurricane losses.

(II) “Eligible risks” means personal lines residential and
commercial lines residential risks that meet the underwriting
criteria of the corporation and are located in areas that were
eligible for coverage by the Florida Windstorm Underwriting
Association on January 1, 2002.

b. The corporation may enter into quota share primary
insurance agreements with authorized insurers at corporation
coverage levels of 90 percent and 50 percent.

c. If the corporation determines that additional coverage
levels are necessary to maximize participation in quota share
primary insurance agreements by authorized insurers, the
corporation may establish additional coverage levels. However, the corporation’s quota share primary insurance coverage level may not exceed 90 percent.

d. Any quota share primary insurance agreement entered into between an authorized insurer and the corporation must provide for a uniform specified percentage of coverage of hurricane losses, by county or territory as set forth by the corporation board, for all eligible risks of the authorized insurer covered under the quota share primary insurance agreement.

e. Any quota share primary insurance agreement entered into between an authorized insurer and the corporation is subject to review and approval by the office. However, such agreement shall be authorized only as to insurance contracts entered into between an authorized insurer and an insured who is already insured by the corporation for wind coverage.

f. For all eligible risks covered under quota share primary insurance agreements, the exposure and coverage levels for both the corporation and authorized insurers shall be reported by the corporation to the Florida Hurricane Catastrophe Fund. For all policies of eligible risks covered under quota share primary insurance agreements, the corporation and the authorized insurer shall maintain complete and accurate records for the purpose of exposure and loss reimbursement audits as required by Florida Hurricane Catastrophe Fund rules. The corporation and the authorized insurer shall each maintain duplicate copies of policy declaration pages and supporting claims documents.

g. The corporation board shall establish in its plan of operation standards for quota share agreements which ensure that there is no discriminatory application among insurers as to the
terms of quota share agreements, pricing of quota share agreements, incentive provisions if any, and consideration paid for servicing policies or adjusting claims.

h. The quota share primary insurance agreement between the corporation and an authorized insurer must set forth the specific terms under which coverage is provided, including, but not limited to, the sale and servicing of policies issued under the agreement by the insurance agent of the authorized insurer producing the business, the reporting of information concerning eligible risks, the payment of premium to the corporation, and arrangements for the adjustment and payment of hurricane claims incurred on eligible risks by the claims adjuster and personnel of the authorized insurer. Entering into a quota sharing insurance agreement between the corporation and an authorized insurer shall be voluntary and at the discretion of the authorized insurer.

3. May provide that the corporation may employ or otherwise contract with individuals or other entities to provide administrative or professional services that may be appropriate to effectuate the plan. The corporation shall have the power to borrow funds, by issuing bonds or by incurring other indebtedness, and shall have other powers reasonably necessary to effectuate the requirements of this subsection, including, without limitation, the power to issue bonds and incur other indebtedness in order to refinance outstanding bonds or other indebtedness. The corporation may, but is not required to, seek judicial validation of its bonds or other indebtedness under chapter 75. The corporation may issue bonds or incur other indebtedness, or have bonds issued on its behalf by a unit of
local government pursuant to subparagraph (p)2., in the absence
of a hurricane or other weather-related event, upon a
determination by the corporation, subject to approval by the
office, that such action would enable it to efficiently meet the
financial obligations of the corporation and that such
financings are reasonably necessary to effectuate the
requirements of this subsection. The corporation is authorized
to take all actions needed to facilitate tax-free status for any
such bonds or indebtedness, including formation of trusts or
other affiliated entities. The corporation shall have the
authority to pledge assessments, projected recoveries from the
Florida Hurricane Catastrophe Fund, other reinsurance
recoverables, market equalization and other surcharges, and
other funds available to the corporation as security for bonds
or other indebtedness. In recognition of s. 10, Art. I of the
State Constitution, prohibiting the impairment of obligations of
contracts, it is the intent of the Legislature that no action be
taken whose purpose is to impair any bond indenture or financing
agreement or any revenue source committed by contract to such
bond or other indebtedness.

4.a. Must require that the corporation operate subject to
the supervision and approval of a board of governors consisting
of eight individuals who are residents of this state, from
different geographical areas of this state. The Governor, the
Chief Financial Officer, the President of the Senate, and the
Speaker of the House of Representatives shall each appoint two
members of the board. At least one of the two members appointed
by each appointing officer must have demonstrated expertise in
insurance, and is deemed to be within the scope of the exemption
provided in s. 112.313(7)(b). The Chief Financial Officer shall designate one of the appointees as chair. All board members serve at the pleasure of the appointing officer. All members of the board of governors are subject to removal at will by the officers who appointed them. All board members, including the chair, must be appointed to serve for 3-year terms beginning annually on a date designated by the plan. However, for the first term beginning on or after July 1, 2009, each appointing officer shall appoint one member of the board for a 2-year term and one member for a 3-year term. Any board vacancy shall be filled for the unexpired term by the appointing officer. The Chief Financial Officer shall appoint a technical advisory group to provide information and advice to the board of governors in connection with the board’s duties under this subsection. The executive director and senior managers of the corporation shall be engaged by the board and serve at the pleasure of the board. Any executive director appointed on or after July 1, 2006, is subject to confirmation by the Senate. The executive director is responsible for employing other staff as the corporation may require, subject to review and concurrence by the board.

b. The board shall create a Market Accountability Advisory Committee to assist the corporation in developing awareness of its rates and its customer and agent service levels in relationship to the voluntary market insurers writing similar coverage. The members of the advisory committee shall consist of the following 11 persons, one of whom must be elected chair by the members of the committee: four representatives, one appointed by the Florida Association of Insurance Agents, one by the Florida Association of Insurance and Financial Advisors, one
by the Professional Insurance Agents of Florida, and one by the Latin American Association of Insurance Agencies; three representatives appointed by the insurers with the three highest voluntary market share of residential property insurance business in the state; one representative from the Office of Insurance Regulation; one consumer appointed by the board who is insured by the corporation at the time of appointment to the committee; one representative appointed by the Florida Association of Realtors; and one representative appointed by the Florida Bankers Association. All members must serve for 3-year terms and may serve for consecutive terms. The committee shall report to the corporation at each board meeting on insurance market issues which may include rates and rate competition with the voluntary market; service, including policy issuance, claims processing, and general responsiveness to policyholders, applicants, and agents; and matters relating to depopulation.

5. Must provide a procedure for determining the eligibility of a risk for coverage, as follows:

a. Subject to the provisions of s. 627.3517, with respect to personal lines residential risks, if the risk is offered coverage from an authorized insurer at the insurer’s approved rate under either a standard policy including wind coverage or, if consistent with the insurer’s underwriting rules as filed with the office, a basic policy including wind coverage, for a new application to the corporation for coverage, the risk is not eligible for any policy issued by the corporation unless the premium for coverage from the authorized insurer is more than 15 percent greater than the premium for comparable coverage from the corporation. If the risk is not able to obtain any such
offer, the risk is eligible for either a standard policy including wind coverage or a basic policy including wind coverage issued by the corporation; however, if the risk could not be insured under a standard policy including wind coverage regardless of market conditions, the risk shall be eligible for a basic policy including wind coverage unless rejected under subparagraph 8. However, with regard to a policyholder of the corporation or a policyholder removed from the corporation through an assumption agreement until the end of the assumption period, the policyholder remains eligible for coverage from the corporation regardless of any offer of coverage from an authorized insurer or surplus lines insurer. The corporation shall determine the type of policy to be provided on the basis of objective standards specified in the underwriting manual and based on generally accepted underwriting practices.

(I) If the risk accepts an offer of coverage through the market assistance plan or an offer of coverage through a mechanism established by the corporation before a policy is issued to the risk by the corporation or during the first 30 days of coverage by the corporation, and the producing agent who submitted the application to the plan or to the corporation is not currently appointed by the insurer, the insurer shall:

(A) Pay to the producing agent of record of the policy, for the first year, an amount that is the greater of the insurer’s usual and customary commission for the type of policy written or a fee equal to the usual and customary commission of the corporation; or

(B) Offer to allow the producing agent of record of the policy to continue servicing the policy for a period of not less
than 1 year and offer to pay the agent the greater of the insurer’s or the corporation’s usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance with sub-sub-sub-subparagraph (A).

(II) When the corporation enters into a contractual agreement for a take-out plan, the producing agent of record of the corporation policy is entitled to retain any unearned commission on the policy, and the insurer shall:

(A) Pay to the producing agent of record of the corporation policy, for the first year, an amount that is the greater of the insurer’s usual and customary commission for the type of policy written or a fee equal to the usual and customary commission of the corporation; or

(B) Offer to allow the producing agent of record of the corporation policy to continue servicing the policy for a period of not less than 1 year and offer to pay the agent the greater of the insurer’s or the corporation’s usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance with sub-sub-sub-subparagraph (A).

b. With respect to commercial lines residential risks, for a new application to the corporation for coverage, if the risk is offered coverage under a policy including wind coverage from an authorized insurer at its approved rate, the risk is not
eligible for any policy issued by the corporation unless the
premium for coverage from the authorized insurer is more than 15
percent greater than the premium for comparable coverage from
the corporation. If the risk is not able to obtain any such
offer, the risk is eligible for a policy including wind coverage
issued by the corporation. However, with regard to a
policyholder of the corporation or a policyholder removed from
the corporation through an assumption agreement until the end of
the assumption period, the policyholder remains eligible for
coverage from the corporation regardless of any offer of
coverage from an authorized insurer or surplus lines insurer.

(I) If the risk accepts an offer of coverage through the
market assistance plan or an offer of coverage through a
mechanism established by the corporation before a policy is
issued to the risk by the corporation or during the first 30
days of coverage by the corporation, and the producing agent who
submitted the application to the plan or the corporation is not
currently appointed by the insurer, the insurer shall:

(A) Pay to the producing agent of record of the policy, for
the first year, an amount that is the greater of the insurer’s
usual and customary commission for the type of policy written or
a fee equal to the usual and customary commission of the
corporation; or

(B) Offer to allow the producing agent of record of the
policy to continue servicing the policy for a period of not less
than 1 year and offer to pay the agent the greater of the
insurer’s or the corporation’s usual and customary commission
for the type of policy written.
If the producing agent is unwilling or unable to accept
appointment, the new insurer shall pay the agent in accordance
with sub-sub-sub-subparagraph (A).

(II) When the corporation enters into a contractual
agreement for a take-out plan, the producing agent of record of
the corporation policy is entitled to retain any unearned
commission on the policy, and the insurer shall:

(A) Pay to the producing agent of record of the corporation
policy, for the first year, an amount that is the greater of the
insurer’s usual and customary commission for the type of policy
written or a fee equal to the usual and customary commission of
the corporation; or

(B) Offer to allow the producing agent of record of the
corporation policy to continue servicing the policy for a period
of not less than 1 year and offer to pay the agent the greater
of the insurer’s or the corporation’s usual and customary
commission for the type of policy written.

If the producing agent is unwilling or unable to accept
appointment, the new insurer shall pay the agent in accordance
with sub-sub-sub-subparagraph (A).

c. For purposes of determining comparable coverage under
sub-subparagraphs a. and b., the comparison shall be based on
those forms and coverages that are reasonably comparable. The
corporation may rely on a determination of comparable coverage
and premium made by the producing agent who submits the
application to the corporation, made in the agent’s capacity as
the corporation’s agent. A comparison may be made solely of the
premium with respect to the main building or structure only on
the following basis: the same coverage A or other building limits; the same percentage hurricane deductible that applies on an annual basis or that applies to each hurricane for commercial residential property; the same percentage of ordinance and law coverage, if the same limit is offered by both the corporation and the authorized insurer; the same mitigation credits, to the extent the same types of credits are offered both by the corporation and the authorized insurer; the same method for loss payment, such as replacement cost or actual cash value, if the same method is offered both by the corporation and the authorized insurer in accordance with underwriting rules; and any other form or coverage that is reasonably comparable as determined by the board. If an application is submitted to the corporation for wind-only coverage in the coastal high-risk account, the premium for the corporation’s wind-only policy plus the premium for the ex-wind policy that is offered by an authorized insurer to the applicant shall be compared to the premium for multiperil coverage offered by an authorized insurer, subject to the standards for comparison specified in this subparagraph. If the corporation or the applicant requests from the authorized insurer a breakdown of the premium of the offer by types of coverage so that a comparison may be made by the corporation or its agent and the authorized insurer refuses or is unable to provide such information, the corporation may treat the offer as not being an offer of coverage from an authorized insurer at the insurer’s approved rate.

6. Must include rules for classifications of risks and rates therefor.

7. Must provide that if premium and investment income for
an account attributable to a particular calendar year are in excess of projected losses and expenses for the account attributable to that year, such excess shall be held in surplus in the account. Such surplus shall be available to defray deficits in that account as to future years and shall be used for that purpose prior to assessing assessable insurers and assessable insureds as to any calendar year.

8. Must provide objective criteria and procedures to be uniformly applied for all applicants in determining whether an individual risk is so hazardous as to be uninsurable. In making this determination and in establishing the criteria and procedures, the following shall be considered:

a. Whether the likelihood of a loss for the individual risk is substantially higher than for other risks of the same class; and

b. Whether the uncertainty associated with the individual risk is such that an appropriate premium cannot be determined.

The acceptance or rejection of a risk by the corporation shall be construed as the private placement of insurance, and the provisions of chapter 120 shall not apply.

9. Must provide that the corporation shall make its best efforts to procure catastrophe reinsurance at reasonable rates, to cover its projected 100-year probable maximum loss as determined by the board of governors.

10. The policies issued by the corporation must provide that, if the corporation or the market assistance plan obtains an offer from an authorized insurer to cover the risk at its approved rates, the risk is no longer eligible for renewal
through the corporation, except as otherwise provided in this subsection.

11. Corporation policies and applications must include a notice that the corporation policy could, under this section, be replaced with a policy issued by an authorized insurer that does not provide coverage identical to the coverage provided by the corporation. The notice shall also specify that acceptance of corporation coverage creates a conclusive presumption that the applicant or policyholder is aware of this potential.

12. May establish, subject to approval by the office, different eligibility requirements and operational procedures for any line or type of coverage for any specified county or area if the board determines that such changes to the eligibility requirements and operational procedures are justified due to the voluntary market being sufficiently stable and competitive in such area or for such line or type of coverage and that consumers who, in good faith, are unable to obtain insurance through the voluntary market through ordinary methods would continue to have access to coverage from the corporation. When coverage is sought in connection with a real property transfer, such requirements and procedures shall not provide for an effective date of coverage later than the date of the closing of the transfer as established by the transferor, the transferee, and, if applicable, the lender.

13. Must provide that, with respect to the coastal high-risk account, any assessable insurer with a surplus as to policyholders of $25 million or less writing 25 percent or more of its total countrywide property insurance premiums in this state may petition the office, within the first 90 days of each
calendar year, to qualify as a limited apportionment company. A
regular assessment levied by the corporation on a limited
apportionment company for a deficit incurred by the corporation
for the coastal high-risk account in 2006 or thereafter may be
paid to the corporation on a monthly basis as the assessments
are collected by the limited apportionment company from its
insureds pursuant to s. 627.3512, but the regular assessment
must be paid in full within 12 months after being levied by the
corporation. A limited apportionment company shall collect from
its policyholders any emergency assessment imposed under sub-
subparagraph (b)3.d. The plan shall provide that, if the office
determines that any regular assessment will result in an
impairment of the surplus of a limited apportionment company,
the office may direct that all or part of such assessment be
defered as provided in subparagraph (p)4. However, there shall
be no limitation or deferment of an emergency assessment to be
collected from policyholders under sub-subparagraph (b)3.d.

14. Must provide that the corporation appoint as its
licensed agents only those agents who also hold an appointment
as defined in s. 626.015(3) with an insurer who at the time of
the agent’s initial appointment by the corporation is authorized
to write and is actually writing personal lines residential
property coverage, commercial residential property coverage, or
commercial nonresidential property coverage within the state.

15. Must provide, by July 1, 2007, a premium payment plan
option to its policyholders which allows at a minimum for
quarterly and semiannual payment of premiums. A monthly payment
plan may, but is not required to, be offered.

16. Must limit coverage on mobile homes or manufactured
homes built prior to 1994 to actual cash value of the dwelling rather than replacement costs of the dwelling.

17. May provide such limits of coverage as the board determines, consistent with the requirements of this subsection.

18. May require commercial property to meet specified hurricane mitigation construction features as a condition of eligibility for coverage.

(d)1. All prospective employees for senior management positions, as defined by the plan of operation, are subject to background checks as a prerequisite for employment. The office shall conduct background checks on such prospective employees pursuant to ss. 624.34, 624.404(3), and 628.261.

2. On or before July 1 of each year, employees of the corporation are required to sign and submit a statement attesting that they do not have a conflict of interest, as defined in part III of chapter 112. As a condition of employment, all prospective employees are required to sign and submit to the corporation a conflict-of-interest statement.

3. Senior managers and members of the board of governors are subject to the provisions of part III of chapter 112, including, but not limited to, the code of ethics and public disclosure and reporting of financial interests, pursuant to s. 112.3145. Notwithstanding s. 112.3143(2), a board member may not vote on any measure that would inure to his or her special private gain or loss; that he or she knows would inure to the special private gain or loss of any principal by whom he or she is retained or to the parent organization or subsidiary of a corporate principal by which he or she is retained, other than an agency as defined in s. 112.312; or that he or she knows
would inure to the special private gain or loss of a relative or
business associate of the public officer. Before the vote is
taken, such member shall publicly state to the assembly the
nature of the his or her interest in the matter from which he or
she is abstaining from voting and, within 15 days after the vote
occurs, disclose the nature of his or her interest as a public
record in a memorandum filed with the person responsible for
recording the minutes of the meeting, who shall incorporate the
memorandum in the minutes. Senior managers and board members are
also required to file such disclosures with the Commission on
Ethics and the Office of Insurance Regulation. The executive
director of the corporation or his or her designee shall notify
each existing and newly appointed member of the board of governors and senior managers of their duty to
comply with the reporting requirements of part III of chapter
112. At least quarterly, the executive director or his or her
designee shall submit to the Commission on Ethics a list of
names of the senior managers and members of the board of
governors who are subject to the public disclosure requirements
under s. 112.3145.

4. Notwithstanding s. 112.3148 or s. 112.3149, or any other
provision of law, an employee or board member may not knowingly
accept, directly or indirectly, any gift or expenditure from a
person or entity, or an employee or representative of such
person or entity, that has a contractual relationship with the
corporation or who is under consideration for a contract. An
employee or board member who fails to comply with subparagraph
3. or this subparagraph is subject to penalties provided under
ss. 112.317 and 112.3173.
5. Any senior manager of the corporation who is employed on or after January 1, 2007, regardless of the date of hire, who subsequently retires or terminates employment is prohibited from representing another person or entity before the corporation for 2 years after retirement or termination of employment from the corporation.

6. Any senior manager of the corporation who is employed on or after January 1, 2007, regardless of the date of hire, who subsequently retires or terminates employment is prohibited from having any employment or contractual relationship for 2 years with an insurer that has entered into a take-out bonus agreement with the corporation.

(y) It is the intent of the Legislature that the amendments to this subsection enacted in 2002 should, over time, reduce the probable maximum windstorm losses in the residual markets and should reduce the potential assessments to be levied on property insurers and policyholders statewide. In furtherance of this intent:

1. The board shall, on or before February 1 of each year, provide a report to the President of the Senate and the Speaker of the House of Representatives showing the reduction or increase in the 100-year probable maximum loss attributable to wind-only coverages and the quota share program under this subsection combined, as compared to the benchmark 100-year probable maximum loss of the Florida Windstorm Underwriting Association. For purposes of this paragraph, the benchmark 100-year probable maximum loss of the Florida Windstorm Underwriting Association shall be the calculation dated February 2001 and based on November 30, 2000, exposures. In order to ensure
comparability of data, the board shall use the same methods for
calculating its probable maximum loss as were used to calculate
the benchmark probable maximum loss.

2. Beginning December 1, 2012, if the report under
subsection 1. for any year indicates that the 100-year
probable maximum loss attributable to wind-only coverages and
the quota share program combined does not reflect a reduction of
at least 25 percent from the benchmark, the board shall reduce
the boundaries of the high-risk area eligible for wind-only
coverages under this subsection in a manner calculated to reduce
such probable maximum loss to an amount at least 25 percent
below the benchmark.

3. Beginning February 1, 2015, if the report under
subsection 1. for any year indicates that the 100-year
probable maximum loss attributable to wind-only coverages and
the quota share program combined does not reflect a reduction of
at least 50 percent from the benchmark, the boundaries of the
high-risk area eligible for wind-only coverages under this
subsection shall be reduced by the elimination of any area that
is not seaward of a line 1,000 feet inland from the Intracoastal
Waterway.

Section 17. The Division of Statutory Revision is directed
to prepare a reviser’s bill for introduction at the next regular
session of the Legislature to change the term “high-risk
account” to “coastal account” to conform the Florida Statutes to
the amendment to s. 627.351(6)(b)2.a.(III), Florida Statutes,
made by this act.

Section 18. Subsection (2) of section 627.4133, Florida
Statutes, is amended to read:
627.4133 Notice of cancellation, nonrenewal, or renewal premium.—

(2) With respect to any personal lines or commercial residential property insurance policy, including, but not limited to, any homeowner’s, mobile home owner’s, farmowner’s, condominium association, condominium unit owner’s, apartment building, or other policy covering a residential structure or its contents:

(a) The insurer shall give the named insured at least 45 days’ advance written notice of the renewal premium.

(b) The insurer shall give the named insured written notice of nonrenewal, cancellation, or termination at least 100 days before the effective date of the nonrenewal, cancellation, or termination. However, the insurer shall give at least 100 days’ written notice, or written notice by June 1, whichever is earlier, for any nonrenewal, cancellation, or termination that would be effective between June 1 and November 30. The notice must include the reason or reasons for the nonrenewal, cancellation, or termination, except that:

1. The insurer must shall give the named insured written notice of nonrenewal, cancellation, or termination at least 180 days before prior to the effective date of the nonrenewal, cancellation, or termination for a named insured whose residential structure has been insured by that insurer or an affiliated insurer for at least a 5-year period immediately prior to the date of the written notice.

2. When cancellation is for nonpayment of premium, at least 10 days’ written notice of cancellation accompanied by the reason therefor must shall be given. As used in this
subparagraph, the term “nonpayment of premium” means failure of the named insured to discharge when due any of her or his obligations in connection with the payment of premiums on a policy or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit, or failure to maintain membership in an organization if such membership is a condition precedent to insurance coverage. “Nonpayment of premium” also means the failure of a financial institution to honor an insurance applicant’s check after delivery to a licensed agent for payment of a premium, even if the agent has previously delivered or transferred the premium to the insurer. If a dishonored check represents the initial premium payment, the contract and all contractual obligations shall be void ab initio unless the nonpayment is cured within the earlier of 5 days after actual notice by certified mail is received by the applicant or 15 days after notice is sent to the applicant by certified mail or registered mail, and if the contract is void, any premium received by the insurer from a third party must be refunded to that party in full.

3. When such cancellation or termination occurs during the first 90 days during which the insurance is in force and the insurance is canceled or terminated for reasons other than nonpayment of premium, at least 20 days’ written notice of cancellation or termination accompanied by the reason therefor shall be given except if there has been a material misstatement or misrepresentation or failure to comply with the underwriting requirements established by the insurer.

4. The requirement for providing written notice of
enrolled by June 1 of any nonrenewal that would be effective
between June 1 and November 30 does not apply to the following
situations, but the insurer remains subject to the requirement
to provide such notice at least 100 days before prior to the
effective date of nonrenewal:

a. A policy that is nonrenewed due to a revision in the
coverage for sinkhole losses and catastrophic ground cover
collapse pursuant to s. 627.706, as amended by s. 30, chapter

b. A policy that is nonrenewed by Citizens Property
Insurance Corporation, pursuant to s. 627.351(6), for a policy
that has been assumed by an authorized insurer offering
replacement or renewal coverage to the policyholder is exempt
from the notice requirements of paragraph (a) and this
paragraph. In such cases, Citizens Property Insurance
Corporation shall give the named insured written notice of
nonrenewal at least 45 days before the effective date of the
nonrenewal.

After the policy has been in effect for 90 days, the policy may
shall not be canceled by the insurer except if when there has
been a material misstatement, a nonpayment of premium, a failure
to comply with underwriting requirements established by the
insurer within 90 days of the date of effectuation of coverage,
or a substantial change in the risk covered by the policy or if
when the cancellation is for all insureds under such policies
for a given class of insureds. This paragraph does not apply to
individually rated risks having a policy term of less than 90
days.
5. Notwithstanding any other provision of law, an insurer may cancel or nonrenew a property insurance policy upon a minimum of 45 days’ notice if the office finds that the early cancellation of some or all of the insurer’s policies is necessary to protect the best interests of the public or policyholders and the office approves the insurer’s plan for early cancellation or nonrenewal of some or all of its policies. The office may base such a finding upon the financial condition of the insurer, lack of adequate reinsurance coverage for hurricane risk, or other relevant factors. The office may condition its finding on the consent of the insurer to be placed in administrative supervision pursuant to s. 624.81 or consent to the appointment of a receiver under chapter 631.

(c) If the insurer fails to provide the notice required by this subsection, other than the 10-day notice, the coverage provided to the named insured shall remain in effect until the effective date of replacement coverage or until the expiration of a period of days after the notice is given equal to the required notice period, whichever occurs first. The premium for the coverage shall remain the same during any such extension period except that, in the event of failure to provide notice of nonrenewal, if the rate filing then in effect would have resulted in a premium reduction, the premium during such extension must be calculated based on the later rate filing.

(d)1. Upon a declaration of an emergency pursuant to s. 252.36 and the filing of an order by the Commissioner of Insurance Regulation, an insurer may not cancel or nonrenew a personal residential or commercial residential property
insurance policy covering a dwelling or residential property located in this state which has been damaged as a result of a hurricane or wind loss that is the subject of the declaration of emergency for a period of 90 days after the dwelling or residential property has been repaired. A structure is deemed to be repaired when substantially completed and restored to the extent that it is insurable by another authorized insurer that is writing policies in this state.

2. However, an insurer or agent may cancel or nonrenew such a policy before the repair of the dwelling or residential property:
   a. Upon 10 days’ notice for nonpayment of premium; or
   b. Upon 45 days’ notice:
      (I) For a material misstatement or fraud related to the claim;
      (II) If the insurer determines that the insured has unreasonably caused a delay in the repair of the dwelling; or
      (III) If the insurer has paid policy limits.

3. If the insurer elects to nonrenew a policy covering a property that has been damaged, the insurer shall provide at least 90 days’ notice to the insured that the insurer intends to nonrenew the policy 90 days after the dwelling or residential property has been repaired. Nothing in this paragraph shall prevent the insurer from canceling or nonrenewing the policy 90 days after the repairs are complete for the same reasons the insurer would otherwise have canceled or nonrenewed the policy but for the limitations of subparagraph 1. The Financial Services Commission may adopt rules, and the Commissioner of Insurance Regulation may issue orders, necessary to implement...
this paragraph.

4. This paragraph shall also apply to personal residential and commercial policies covering property that was damaged as the result of Tropical Storm Bonnie, Hurricane Charley, Hurricane Frances, Hurricane Ivan, or Hurricane Jeanne.

(e) If any cancellation or nonrenewal of a policy subject to this subsection is to take effect during the duration of a hurricane as defined in s. 627.4025(2)(c), the effective date of such cancellation or nonrenewal is extended until the end of the duration of such hurricane. The insurer may collect premium at the prior rates or the rates then in effect for the period of time for which coverage is extended. This paragraph does not apply to any property with respect to which replacement coverage has been obtained and which is in effect for a claim occurring during the duration of the hurricane.

Section 19. Section 627.43141, Florida Statutes, is created to read:

627.43141 Notice of change in policy terms.—

(1) As used in this section, the term:

(a) “Change in policy terms” means the modification, addition, or deletion of any term, coverage, duty, or condition from the previous policy. The correction of typographical or scrivener’s errors or the application of mandated legislative changes is not a change in policy terms.

(b) “Policy” means a written contract of personal lines property insurance or a written agreement for insurance, or the certificate of such insurance, by whatever name called, and includes all clauses, riders, endorsements, and papers that are
a part of such policy. The term does not include a binder as
defined in s. 627.420 unless the duration of the binder period
exceeds 60 days.

(c) “Renewal” means the issuance and delivery by an insurer
of a policy superseding at the end of the policy period a policy
previously issued and delivered by the same insurer or the
issuance and delivery of a certificate or notice extending the
term of a policy beyond its policy period or term. Any policy
that has a policy period or term of less than 6 months or any
policy that does not have a fixed expiration date shall, for
purposes of this section, be considered as written for
successive policy periods or terms of 6 months.

(2) A renewal policy may contain a change in policy terms.
If a renewal policy contains a change in policy terms, the
insurer shall give the named insured a written notice of the
change in policy terms, which must be enclosed along with the
written notice of renewal premium required by ss. 627.4133 and
627.728. Such notice should be entitled “Notice of Change in
Policy Terms.”

(3) Although not required, proof of mailing or registered
mailing through the United States Postal Service of the Notice
of Change in Policy Terms to the named insured at the address
shown in the policy is sufficient proof of notice.

(4) Receipt of payment of the premium for the renewal
policy by the insurer is deemed to be acceptance of the new
policy terms by the named insured.

(5) If an insurer fails to provide the notice required in
subsection (2), the original policy terms shall remain in effect
until the next renewal and the proper service of the notice or
until the effective date of replacement coverage obtained by the
named insured, whichever occurs first.

(6) The intent of this section is to:

(a) Allow an insurer to make a change in policy terms
without nonrenewing policyholders that the insurer wishes to
continue insuring.

(b) Alleviate concern and confusion to the policyholder
caused by the required policy nonrenewal for the limited issue
when an insurer intends to renew the insurance policy but the
new policy contains a change in policy terms.

(c) Encourage policyholders to discuss their coverages with
their insurance agents.

Section 20. Section 627.7011, Florida Statutes, is amended
to read:

627.7011 Homeowners’ policies; offer of replacement cost
coverage and law and ordinance coverage.—

(1) Before Prior to issuing or renewing a homeowner’s
insurance policy on or after October 1, 2005, or prior to the
first renewal of a homeowner’s insurance policy on or after
October 1, 2005, the insurer must offer each of the following:

(a) A policy or endorsement providing that any loss which
is repaired or replaced will be adjusted on the basis of
replacement costs not exceeding policy limits as to the
dwelling, rather than actual cash value, but not including costs
necessary to meet applicable laws and ordinances regulating the
construction, use, or repair of any property or requiring the
tearing down of any property, including the costs of removing
debris.

(b) A policy or endorsement providing that, subject to
other policy provisions, any loss which is repaired or replaced at any location will be adjusted on the basis of replacement costs not exceeding policy limits as to the dwelling, rather than actual cash value, and also including costs necessary to meet applicable laws and ordinances regulating the construction, use, or repair of any property or requiring the tearing down of any property, including the costs of removing debris. However, such additional costs necessary to meet applicable laws and ordinances may be limited to either 25 percent or 50 percent of the dwelling limit, as selected by the policyholder, and such coverage shall apply only to repairs of the damaged portion of the structure unless the total damage to the structure exceeds 50 percent of the replacement cost of the structure.

An insurer is not required to make the offers required by this subsection with respect to the issuance or renewal of a homeowner’s policy that contains the provisions specified in paragraph (b) for law and ordinance coverage limited to 25 percent of the dwelling limit, except that the insurer must offer the law and ordinance coverage limited to 50 percent of the dwelling limit. This subsection does not prohibit the offer of a guaranteed replacement cost policy.

(2) Unless the insurer obtains the policyholder’s written refusal of the policies or endorsements specified in subsection (1), any policy covering the dwelling is deemed to include the law and ordinance coverage limited to 25 percent of the dwelling limit. The rejection or selection of alternative coverage shall be made on a form approved by the office. The form shall fully advise the applicant of the nature of the coverage being
rejected. If this form is signed by a named insured, it will be conclusively presumed that there was an informed, knowing rejection of the coverage or election of the alternative coverage on behalf of all insureds. Unless the policyholder requests in writing the coverage specified in this section, it need not be provided in or supplemental to any other policy that renews, insures, extends, changes, supersedes, or replaces an existing policy when the policyholder has rejected the coverage specified in this section or has selected alternative coverage. The insurer must provide such policyholder with notice of the availability of such coverage in a form approved by the office at least once every 3 years. The failure to provide such notice constitutes a violation of this code, but does not affect the coverage provided under the policy.

(3)(a) In the event of a loss for which a dwelling is insured on the basis of replacement costs, the insurer initially must pay at least the actual cash value of the insured loss, less any applicable deductible. An insured shall subsequently enter into a contract for the performance of building and structural repairs. The insurer shall pay any remaining amounts incurred to perform such repairs as the work is performed. With the exception of incidental expenses to mitigate further damage, the insurer or any contractor or subcontractor may not require the policyholder to advance payment for such repairs or expenses. The insurer may waive the requirement for a contract as provided in this paragraph. An insured shall have a period of one 1 year after the date the insurer pays actual cash value to make a claim for replacement cost. If a total loss of a dwelling occurs, the insurer shall pay the replacement cost coverage.
without reservation or holdback of any depreciation in value, pursuant to s. 627.702.

(b) In the event of a loss for which a dwelling or personal property is insured on the basis of replacement costs, the insurer shall pay the replacement cost without reservation or holdback of any depreciation in value, whether or not the insured replaces or repairs the dwelling or property.

(4) A homeowner’s insurance policy issued or renewed on or after October 1, 2005, must include in bold type no smaller than 18 points the following statement:

“LAW AND ORDINANCE COVERAGE IS AN IMPORTANT COVERAGE THAT YOU MAY WISH TO PURCHASE. YOU MAY ALSO NEED TO CONSIDER THE PURCHASE OF FLOOD INSURANCE FROM THE NATIONAL FLOOD INSURANCE PROGRAM. WITHOUT THIS COVERAGE, YOU MAY HAVE UNCOVERED LOSSES. PLEASE DISCUSS THESE COVERAGES WITH YOUR INSURANCE AGENT.”

The intent of this subsection is to encourage policyholders to purchase sufficient coverage to protect them in case events excluded from the standard homeowners policy, such as law and ordinance enforcement and flood, combine with covered events to produce damage or loss to the insured property. The intent is also to encourage policyholders to discuss these issues with their insurance agent.

(5) Nothing in this section does not apply to policies not considered to be “homeowners’ policies,” as that term is commonly understood in the insurance industry. This section specifically does not apply to mobile home policies. Nothing in this section does not limit shall be
enrolled as limiting the ability of any insurer to reject or nonrenew any insured or applicant on the grounds that the structure does not meet underwriting criteria applicable to replacement cost or law and ordinance policies or for other lawful reasons.

(6) This section does not prohibit an insurer from limiting its liability under a policy or endorsement providing that loss will be adjusted on the basis of replacement costs to the lesser of:

(a) The limit of liability shown on the policy declarations page;

(b) The reasonable and necessary cost to repair the damaged, destroyed, or stolen covered property; or

(c) The reasonable and necessary cost to replace the damaged, destroyed, or stolen covered property.

(7) This section does not prohibit an insurer from exercising its right to repair damaged property in compliance with its policy and s. 627.702(7).

Section 21. Paragraph (a) of subsection (5) of section 627.70131, Florida Statutes, is amended to read:

627.70131 Insurer’s duty to acknowledge communications regarding claims; investigation.—

(5)(a) Within 90 days after an insurer receives notice of an initial or supplemental property insurance claim from a policyholder, the insurer shall pay or deny such claim or a portion of the claim unless the failure to pay such claim or a portion of the claim is caused by factors beyond the control of the insurer which reasonably prevent such payment. Any payment of an initial or supplemental claim or portion of such claim
made paid 90 days after the insurer receives notice of the claim, or made paid more than 15 days after there are no longer factors beyond the control of the insurer which reasonably prevented such payment, whichever is later, shall bear interest at the rate set forth in s. 55.03. Interest begins to accrue from the date the insurer receives notice of the claim. The provisions of this subsection may not be waived, voided, or nullified by the terms of the insurance policy. If there is a right to prejudgment interest, the insured shall select whether to receive prejudgment interest or interest under this subsection. Interest is payable when the claim or portion of the claim is paid. Failure to comply with this subsection constitutes a violation of this code. However, failure to comply with this subsection shall not form the sole basis for a private cause of action.

Section 22. Section 627.711, Florida Statutes, is amended to read:

627.711 Notice of premium discounts for hurricane loss mitigation; uniform mitigation verification inspection form.—

(1) Using a form prescribed by the Office of Insurance Regulation, the insurer shall clearly notify the applicant or policyholder of any personal lines residential property insurance policy, at the time of the issuance of the policy and at each renewal, of the availability and the range of each premium discount, credit, other rate differential, or reduction in deductibles, and combinations of discounts, credits, rate differentials, or reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm can be or have been installed.
or implemented. The prescribed form shall describe generally what actions the policyholders may be able to take to reduce their windstorm premium. The prescribed form and a list of such ranges approved by the office for each insurer licensed in the state and providing such discounts, credits, other rate differentials, or reductions in deductibles for properties described in this subsection shall be available for electronic viewing and download from the Department of Financial Services’ or the Office of Insurance Regulation’s Internet website. The Financial Services Commission may adopt rules to implement this subsection.

(2) (a) By July 1, 2007, The Financial Services Commission shall develop by rule a uniform mitigation verification inspection form that shall be used by all insurers when submitted by policyholders for the purpose of factoring discounts for wind insurance. In developing the form, the commission shall seek input from insurance, construction, and building code representatives. Further, the commission shall provide guidance as to the length of time the inspection results are valid. An insurer shall accept as valid a uniform mitigation verification form certified by the Department of Financial Services or signed by the following authorized mitigation inspectors:

1. (a) A home inspector licensed under s. 468.8314 who has completed at least 3 hours of hurricane mitigation training which includes hurricane mitigation techniques and compliance with the uniform mitigation verification form and completion of a proficiency exam. Thereafter, home inspectors licensed under s. 468.8314, must complete at least 2 hours of continuing
education, as part of the existing licensure renewal requirements each year, related to mitigation inspection and the uniform mitigation form hurricane mitigation inspector certified by the My Safe Florida Home program;

2. (b) A building code inspector certified under s. 468.607;
3. (c) A general, building, or residential contractor licensed under s. 489.111;
4. (d) A professional engineer licensed under s. 471.015 who has passed the appropriate equivalency test of the building code training program as required by s. 553.841;
5. (e) A professional architect licensed under s. 481.213;
or
6. (f) Any other individual or entity recognized by the insurer as possessing the necessary qualifications to properly complete a uniform mitigation verification form.

(b) An insurer may, but is not required to, accept a form from any other person possessing qualifications and experience acceptable to the insurer.

(3) A person who is authorized to sign a mitigation verification form must inspect the structures referenced by the form personally, not through employees or other persons, and must certify or attest to personal inspection of the structures referenced by the form. However, licensees under s. 489.111, may authorize a direct employee, who is not an independent contractor, and who possesses the requisite skill, knowledge and experience to conduct a mitigation verification inspection. Insurers shall have the right to request and obtain information from the authorized mitigation inspector under s. 489.111, regarding any authorized employee’s qualifications prior to
accepting a mitigation verification form performed by an employee that is not licensed under s. 489.111.

(4) An authorized mitigation inspector that signs a uniform mitigation form, and a direct employee authorized to conduct mitigation verification inspections under paragraph (3), may not commit misconduct in performing hurricane mitigation inspections or in completing a uniform mitigation form that causes financial harm to a customer or their insurer; or that jeopardizes a customer’s health and safety. Misconduct occurs when an authorized mitigation inspector signs a uniform mitigation verification form that:

(a) Falsely indicates that he or she personally inspected the structures referenced by the form;

(b) Falsely indicates the existence of a feature which entitles an insured to a mitigation discount which the inspector knows does not exist or did not personally inspect;

(c) Contains erroneous information due to the gross negligence of the inspector; or

(d) Contains a pattern of demonstrably false information regarding the existence of mitigation features that could give an insured a false evaluation of the ability of the structure to withstand major damage from a hurricane endangering the safety of the insured’s life and property.

(5) The licensing board of an authorized mitigation inspector that violates subsection (4) may commence disciplinary proceedings and impose administrative fines and other sanctions authorized under the authorized mitigation inspector’s licensing act. Authorized mitigation inspectors licensed under s. 489.111, shall be directly liable for the acts of employees that violate
subsection (4) as if the authorized mitigation inspector personally performed the inspection.

(6) An insurer, person, or other entity that obtains evidence of fraud or evidence that an authorized mitigation inspector or an employee authorized to conduct mitigation verification inspections under paragraph (3), has made false statements in the completion of a mitigation inspection form shall file a report with the Division of Insurance Fraud, along with all of the evidence in its possession that supports the allegation of fraud or falsity. An insurer, person, or other entity making the report shall be immune from liability in accordance with s. 626.989(4), for any statements made in the report, during the investigation, or in connection with the report. The Division of Insurance Fraud shall issue an investigative report if it finds that probable cause exists to believe that the authorized mitigation inspector, or an employee authorized to conduct mitigation verification inspections under paragraph (3), made intentionally false or fraudulent statements in the inspection form. Upon conclusion of the investigation and a finding of probable cause that a violation has occurred, the Division of Insurance Fraud shall send a copy of the investigative report to the office and a copy to the agency responsible for the professional licensure of the authorized mitigation inspector, whether or not a prosecutor takes action based upon the report.

(7) An individual or entity who knowingly provides or utters a false or fraudulent mitigation verification form with the intent to obtain or receive a discount on an insurance premium to which the individual or entity is not entitled...
commits a misdemeanor of the first degree, punishable as
provided in s. 775.082 or s. 775.083.

(8) At its expense, the insurer may require that any
uniform mitigation verification form provided by an authorized
mitigation inspector or inspection company be independently
verified by an inspector, inspection company or an independent
third-party quality assurance provider which does possess a
quality assurance program prior to accepting the uniform
mitigation verification form as valid.

Section 23. Section 628.252, Florida Statutes, is created
to read:

628.252 Servicing affiliates of domestic property
insurers.—Every domestic property insurer shall notify the
office of its intention to enter into with affiliates all
management agreements, service contracts, and cost-sharing
arrangements. A domestic property insurer may not enter into
such an agreement, contract, or arrangement unless the insurer
has it has provided the office with at least 30 days’ written
notice of its intention to enter into such agreement, contract,
or arrangement, or such shorter period as the office, in its
discretion, may permit and the office has not disapproved such
agreement, contract, or arrangement within such period. This
section does not limit any existing authority of the office.

Section 24. The sums of $263,200 in nonrecurring funds and
$47,500 in recurring funds from the Insurance Regulatory Trust
Fund are appropriated and one full-time equivalent position and
associated salary rate is authorized to the Office of Insurance
Regulation to implement the provisions of the act relating to
the design, development, and operation of a comprehensive
website for consumers which provides comparisons of homeowners’
insurance rates and products.

Section 25. Except as otherwise expressly provided in this act and except for this section, which shall take effect June 1, 2010, this act shall take effect July 1, 2010.