HEALTH FLEX PLAN
PROVIDER APPLICATION

Revised June 2008

Agency for Health Care Administration
2727 Mahan Drive, MS 26
Tallahassee, FL 32308
1-888-419-3456

www.FloridaHealthFinder.gov
www.myflorida.com

Office of Insurance Regulation
of the Financial Service Commission
200 East Gaines Street
Tallahassee, Florida 32399-0326
1-850- 413-5002
www.fldfs.com

Florida Department of Financial Services

The Treasurer of the State of Florida
Department of Financial Services

HEALTH FLEX PLAN APPLICATION

The Agency for Health Care Administration (Agency) and Office of Financial Regulation (Office) welcome your interest in the health flex plan program established in Chapter 408.909, Florida Statutes. The program was established in 2002, and was recently amended by the 2008 Legislature. The program is authorized through July 1, 2013. The Agency and the Office have jointly created this application package as an aid in preparing your application to participate in the pilot program. This package is designed for download to a PC allowing applicants to enter responses to each item.

The application package consists of six sections:

Section I General Information Regarding the Applicant

Section II Application Instructions

Section III Agency Quality of Care Review Standards

Section IV Agency Access Review Standards

Section V Office Financial Review Standards

Section VI Office Form and Rate Review

Each section describes the information that must be submitted for review and approval by the Agency or the Office.

In order to be considered, an application must be complete. The Agency and the Office shall each review complete applications in the context of statutory provisions and review criteria developed by the Agency and the Office.

Questions about the application review process and Sections I through IV of the application should be directed to:

Ann Brattain, AHC Administrator
Agency for Health Care Administration
Bureau of Managed Health Care
Phone: 850-487-0640
e-mail: brattaia@ahca.myflorida.com

Questions about Section V regarding financial requirements should be directed to:

Toma Wilkerson, Office of Insurance Regulation
Life and Health Financial Oversight
Phone 850-413- 2458
e-mail: toma.wilkerson@floir.com

Questions related to Section VI regarding forms should be directed to:

Gary Edenfield, Office of Insurance Regulation
Bureau of Life and Health Forms and Rates
Phone 850-413-5134
e-mail: gary.edenfield@floir.com

Questions related to Section VI regarding premium rates should be directed to:

Dan Keating, FSA, Office of Insurance Regulation
Bureau of Life and Health Forms and Rates
Phone 850-413-5144
e-mail: dan.keating.@floir.com

Please read the instructions and the application carefully and answer each question in each section to the best of your knowledge. A checklist is provided for your convenience to verify that all questions in each section have been answered.

CHECKLIST

THIS CHECKLIST IS PROVIDED TO ENSURE THAT THE APPLICANT HAS RESPONDED TO ALL APPLICABLE REQUIREMENTS. THE COMPLETED CHECKLIST MUST BE INCLUDED WITH THE APPLICATION.

Check the box next to each applicable requirement indicating that response was provided.

SECTION I APPLICANT INFORMATION

The type of entity offering the plan has been identified. ☐

The counties of plan operation have been identified. ☐

The affidavit has been completed. ☐

SECTION II APPLICATION INSTRUCTIONS

Section II contains the instructions for the application, a checklist is not applicable to this section. ☐

SECTION III QUALITY OF CARE REVIEW CRITERIA

3.1 Coordination with existing community services has been addressed. ☐

3.2 A description of how the plan will be coordinated with existing governmental or community-based health services program has been provided. ☐

A marketing plan describing the strategies employed to reach the eligible population group has been provided. ☐

A description of the eligibility determination process has been provided. ☐

3.3 A description of the benefits offered through the health flex plan has been provided. ☐

A description of the service delivery system has been provided. ☐

3.4 (a) The listing of mandatory benefits has been checked. ☐

(b) The amount of claims paid per year (cap limits) per enrollee has been identified. ☐

3.5 A listing of reasons for denial, nonrenewal, or cancellation of coverage is provided. ☐

3.7.1 A detailed description of the internal quality assurance program is provided, including a description of the utilization review and incidence-reporting program. ☐

3.7.2 A listing of quality of care indicators is provided. ☐

3.7.3 The applicant understands that physicians have to be licensed or credentialed. ☐

3.7.4 A detailed description of the provider network is provided. ☐

SECTION IV ACCESS TO HEALTH CARE REVIEW CRITERIA

4.1 (a) The estimated number of primary care physicians to the estimated number of enrollees is provided. ☐

(b) The number of primary care physician visits annually is provided. ☐

(c) The number of health care screenings by type is provided. ☐

(d) The number of mental health visits is indicated (if applicable). ☐

(e) The number of hospital days covered annually is provided. ☐

(f) The number of laboratory tests allowed annually by type is provided. ☐

(g) Projected waiting times for specific specialist referrals (if applicable) are provided. ☐

(h) Other. ☐

4.2 A detailed description of the internal grievance process is provided. ☐

4.3 The applicant understands that a consumer satisfaction survey must be conducted biannually and the data must be submitted to the Agency and the Office ☐

SECTION V FINANCIAL REVIEW STANDARDS

ONLY APPLICABLE FOR ENTITIES OTHER THAN AUTHORIZED HEALTH INSURERS OR AUTHORIZED HEALTH MAINTENANCE ORGANIZATIONS

5.1.2 Local government and health care district entities have provided documentation that they have taxing authority to support this program. ☐

A statement has been submitted that the projected working capital needs and the initial expenses of the proposed plan are available from current accounts and general revenue sources. ☐

Documentation is provided that the revenue stream of financial resources is available to support the liabilities of the plan. ☐

5.1.3 The applicant understands the surplus requirements to be maintained for the type of benefits to be offered and has provided documentation that the applicant has the financial means to maintain or exceed the surplus requirements. ☐

The amount identified (see instructions) to be maintained based on the benefits to be offered by the applicant $_____. ☐

5.2 The applicant understands the filing requirements specified in this section once the plan is approved. ☐

5.2.3 Health Care Provider Sponsored Organization, public or private community-based organizations, or a public/private partnership, understand that they shall maintain segregated records for the health flex plan and make filings in accordance with the requirements of this section. ☐

5.3 Entities have demonstrated that the ownership, control, and management entity operating the health flex plan are competent in accordance with the provision of this section. ☐

5.3.2 Entities other than HMOs and insurers have provided documentation that the owners, officers, directors, and key personnel meet the background requirements specified. ☐

5.4.2 Local government and health care districts: The chief individual for operating the plan, the chief individual responsible for handling premium receipts, the chief accounting officer of the plan, the chief individual responsible for claims payments have been identified. ☐

5.4.3 All other entities: The names and titles of all officers, directors, key personnel, and all stockholders that own over 10% of the entity have been included. Names must include first, middle, and last name with no abbreviation. ☐

5.4.4 Filing Requirements (other than Health Insurers and HMOs) ☐

(a) Owners, directors, or officers of the plan have been identified. ☐

(b) The biographical affidavits (Form OIR-C1 1423) have been completed and included for each person listed above and the social security number for each person completing the biographical statement has been recorded on a separate page and marked confidential. ☐

(c) A background investigation report on the individuals identified above has been ordered per the instructions. ☐

(d) Fingerprint cards for each person identified above have been included, including the processing fee. The processing fee has to be submitted with the application submitted to the Office. ☐

(e) Proforma projections showing the assets, liabilities, expenses, surplus, and premium volume projected for the plan by quarter for two years have been attached. ☐

(f) The source, type, and amount of funding for the initial capitalization of the plan and the contingent plan for additional funding have been described. ☐

Proof is attached that the initial funding exists and that the assets consist of those specified as being admitted. ☐

(g) An explanation of how records are being segregated from other operations has been included. ☐

(h) The feasibility study by an actuary and CPA is attached. ☐

☐

(i) Background information on your organization regarding its history, function, purpose, and experience is included. ☐

(j) Evidence that the corporation is registered and in good standing with the Florida Secretary of State has been included. ☐

(k) A copy of the most recent independent financial audit of the organization has been included. ☐

(l) An organizational chart showing all related corporate entities and the ultimate controlling party has been provided. ☐

(m) Evidence of public liability insurance, fidelity insurance, and medical malpractice insurance that extends to the operation of the health flex benefit plan have been included. ☐

5.5 The applicant will comply with the reporting requirements specified in Section 5.5. ☐

SECTION VI FORMS AND RATE REVIEW STANDARDS

6.1 The plan of operations includes the minimum requirements. ☐

6.2.2 A copy of the enrollment form to be utilized by individuals seeking coverage has been included. ☐

6.2.3 A copy of the evidence of coverage is included as specified in this section, and the issues, instructions, and comments required regarding the issue of "creditable coverage" have been addressed in the material submitted. ☐

6.3.1 A rate schedule or manual has been included. ☐

6.3.2 The actuarial memorandum is included in compliance with this section. ☐

6.4 The applicant agrees to comply with the reporting requirements in this section. ☐

Comments or an explanation why any of the required documentation and forms were not provided:

_____
_____
_____
_____
_____

AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF INSURANCE REGULATION
HEALTH FLEX PLAN APPLICATION

SECTION I APPLICANT INFORMATION

LEGAL NAME OF APPLICANT: _____

MAILING ADDRESS: _____

AUTHORIZED REPRESENTATIVE/ CHIEF EXECUTIVE OFFICER
CONTACT PERSON
NAME: _____ **NAME:** _____

ADDRESS: _____ **ADDRESS:** _____

TELEPHONE #: _____ **PHONE:** _____

E-MAIL ADDRESS: _____ **E-MAIL:** _____

Organization Type

Licensed Health Insurer (Chapter 624, F.S.) ☐

Health Maintenance Organization (Chapter 641, F.S.) ☐

Prepaid Health Clinic (Chapter 641, Part II, F.S.) ☐

Fraternal Benefit Society (Chapter 632, F.S.) ☐

Prepaid Limited Health Plan (Chapter 636, Part I, F.S.) ☐

Local Government Entity

_____
Name of Entity Assuming Risk for Proposed Plan

Health Care Sponsored Provider Organization:

_____
Name of Organization Assuming Risk for Proposed Plan

Health Care District:

_____
Name of Health Care District Assuming Risk for Proposed Plan

Public or Private Community-based Organization:

_____

Name of Organization Assuming Risk for Proposed Plan

Public/ Private Partnership:

_____

Name of Organization Assuming Risk for Proposed Plan

Proposed Counties of Operation

_____

_____

AFFIDAVIT (AUTHORIZED COMPANY OFFICER)

I_____ hereby swear (or affirm) that under penalties of perjury that I have read the statements in this application for approval to offer a health care flex benefit plan by

_____

Name of Entity

and such statements in this application are true and correct to the best of my knowledge and belief.

I understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree pursuant to section 827.06, Florida Statutes.

Subscribed and sworn to before me this_____day of ____, 20__

_____ _____

Notary Public Name (please type)

_____

Title

_____

Signature

Personally Known ___ or ID Produced: _____

Type of ID Produced: _____

SECTION II APPLICATION INSTRUCTIONS

2.1 Geographic Areas

Applications for the establishment of Health Flex Plan pilot programs shall be accepted for all counties of the state

2.2 Eligible Health Flex Plan Applicants

A Health Flex Plan may be offered by the following entities Please make a check mark next to the applicable category (s.408.909(2)(f), F.S.).

Health Insurer	☐
Health Maintenance Organization	☐
Health Care Provider Sponsored Organization	☐
Local Government	☐
Health Care District	☐
Other Public or Private Community-Based Organization	☐
Public Private Partnership	☐

Health Insurers: A health insurer, for the purpose of this application, includes an insurer authorized to provide health insurance by Chapter 624, F.S.; a fraternal benefit society authorized to provide health insurance by Chapter 632, F.S.; a prepaid limited health plan authorized by Chapter 636, Part I, F.S.; and a prepaid health clinic authorized by Chapter 641 Part II, F.S.

Health Maintenance Organization (HMO): A Health Maintenance Organization for the purpose of this application is defined as an HMO that holds a certificate of authority issued by the Office, and a health care provider certificate issued by the Agency, authorized by Chapter 641, Parts I and III, F.S.

Local Government: Local Government for the purpose of this application is defined as a Local Government Entity with Taxing Authority to support the obligations of the health flex plan for its entire duration.
Health Care District: Health Care District for the purpose of this application is defined as a Health Care District with taxing authority to support the obligations of the health flex plan for its entire duration.

Health Care Provider Sponsored Organizations (PSO), other Public or Private Community-Based Organizations, or a public/private partnership: A PSO is a public or private entity established by health care providers or a group of affiliated providers that provide a substantial proportion of health care items and services directly through providers or affiliated groups of

providers. Affiliated providers share, directly of indirectly, substantial financial risk, and have a t least a majority financial interest in the PSO. For the purpose of this application public or private community-based organizations include, but are not limited to, physician groups, hospital providers, and Provider Services Networks (PSNs).

Public/private partnerships include, but are not limited to, partnerships between public entities, such as county governments, and other health care organizations.

Important Note:

License requirements: Neither the licensing requirements of the Florida Insurance Code nor chapter 641, F.S., regulating HMOs, are applicable to the operation of a Health Flex Plan. However, for the purpose of prohibiting unfair trade practices, Health Flex Plans are considered to be insurance subject to the applicable provisions of part IX of Chapter 626, F.S., (s. 408.909(4), F.S.).

However, section 408.909(3), F.S., directs the Agency and the Office to approve or disapprove health flex plans.

2.3 Application Submission

Applications for the establishment of a Health Flex Plan shall be submitted to the Agency and the Office at the same time. The applications shall be submitted in ring binders.

Applications for the establishment of a Health Flex Plan shall be accepted by the Agency and the Office during regular working hours, 8 a.m. to 5 p.m., Monday through Friday, at any time during the year, until the law authorizing this program expires. The law expires July 1, 2008, unless it is reauthorized prior to the expiration date.

One copy of the application with original signatures must be submitted to:

The Agency for Health Care Administration
Bureau of Managed Health Care, Bldg. 1, (Mail stop 26)
2727 Mahan Drive
Tallahassee, FL 32308

Two copies of the application (one copy with original signatures) must be submitted to:

Office of Insurance Regulation
Application Coordination Section
Room 131, Larson Building
200 East Gaines Street
Tallahassee, FL 32399-0332

The Agency and the Office shall review the application in the context of statutory provisions and review criteria developed by the Agency and the Office.

2.4 Completeness Review

Within 10 days after the Agency and the Office receive the application, the Agency and the Office will each determine if the application is complete. If the application is deemed incomplete, the Agency and/or the Office shall request in writing from the applicant specific information necessary to deem the application complete. If the applicant does not provide the requested information within 30 days of the request, the application is considered withdrawn. The applicant will be notified in writing of the status of the application.

2.5 Approval Timeframes

The Agency and the Office intend to complete the application review process within 60 days after the application is deemed complete. When the review is completed and both the Agency and the Office approve the application, the applicant will be notified in writing. If the Agency and/or the Office determine that the applicant does not meet all applicable review criteria and the application is disapproved, the reasons for the disapproval shall be provided to the applicant in writing. The Agency and Office will make every effort to assist the applicant in the development of the application.

Applicants that propose managed care type plans and do not have written contracts or agreements with all providers in the Health Flex Plan network but meet all other review criteria, shall receive preliminary approval and will receive final approval once the provider contracts or agreements have been signed.

SECTION III QUALITY OF CARE REVIEW CRITERIA

3.1 Coordination with Existing Community Programs

A Health Flex Plan should be coordinated with existing governmental or community-based health services programs in a manner that is consistent with the objectives and requirements of such programs (s. 408.909 (1), F.S.).

Please describe how you intend to meet this requirement. Indicate any services (e.g. case management) you intend to provide for persons enrolled in the health flex plan needing follow-up care not provided by your plan. For instance, if your plan provides primarily preventive and diagnostic services, describe how you will ensure that enrollees obtain the necessary follow-up treatment. Describe existing indigent care programs in the counties you intend to coordinate with and indicate how you plan to coordinate your program with existing community programs.

3.2 Eligible Subscribers

The Legislature finds that a significant proportion of the residents of this state are unable to obtain affordable health insurance coverage. Therefore, it is the intent of the Legislature to expand the availability of health options for low-income uninsured state residents by encouraging health insurers, health maintenance organizations, health care-provider sponsored organizations, local governments, health care districts or other public or private community-sponsored organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services (s. 408.909(1),F.S.).

Eligibility to enroll in an approved Health Flex Plan is limited to residents of this state who: (a) are 64 years of age or younger; (b) have a family income equal to or less than 300 percent of the federal poverty level; (c) are not covered by a private insurance policy and are not eligible for coverage through a public health care program, such as Medicare or Medicaid, or another public health program, such as KidCare, and have not been covered at any time during the past 6 months; except that

1. A person who was covered under an individual health maintenance contract licensed under part I of chapter 641, which was also an approved health flex plan on Ocober 1, 2008, may apply for coverage in the same health maintenance organization's health flex plan without a lapse of coverage if all other eligibility requirements are met; or

2. A person was coverered under Medicaid or Kidcare and lost eligibility for the Medicaid or Kidcare subsidy due to income restrictions within 90 days prior to applying for health care coverage through an approved health flex plan may apply for coverage in a health flex plan without a lapse in coverage if all other eligibility requirements are met; and

3. Have applied for health care coverage as an individual through an approved health plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or

4. Are part of an employee group of which at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level and the employer group is not covered by a private health insurance policy and has not been covered at any time during the past 6 months. If the health flex plan entity is a health insurer, health plan, or health maintenance organization licensed under Florida law, only 50 of the employees must meet the income requirements for the purpose of this paragraph.

Enrollees may purchase coverage directly from the plan or through a small business purchasing arrangement sponsored by a local government.

2009 HHS Poverty Guidelines (except Alaska and Hawaii)

Size of Family	100 %	300%
1	$10,830	$32,490
2	$14,570	$43,710
3	$18,310	$54,930
4	$22,050	$66,150
5	$25,790	$77,370
6	$29,530	$88,590
7	$33,270	$99,810
8	$37,010	$111,030
For each additional person add	$11,220	

For clarification, persons eligible for local indigent health care programs (other than Medicaid) are not excluded from participating in the health flex plan pilot program.

(a) Describe your strategy, including your marketing efforts to reach the eligible population group. A marketing plan shall be included.

(b) Describe the eligibility determination process you intend to employ. Note that persons eligible for Medicaid do not qualify for this program. To avoid any conflict of interest, it is preferable that eligibility determination be performed by an independent entity.

3.3 Service Delivery System

Health Flex Plan coverage means health care services that are covered as benefits under an approved Health Flex Plan or that are otherwise provided, either directly or through arrangements with other persons, via a Health Flex Plan or a prepaid-per-capita basis or on a prepaid fixed sum basis-(s. 408.909(2)(d), F.S.).

Give a detailed description of all the benefits offered through the health flex plan and the service delivery system. Indicate which services are provided directly or through arrangement with other providers; and indicate whether the services are provided on a prepaid-per-capita basis or on a prepaid fixed sum basis.

Note, the Health Flex Plan policy (evidence of coverage) must state in not less than 10 point type on the first page in contrasting color that:

"The benefits provided by this health plan are limited. You should carefully review the benefits offered under this health plan."

The Health Flex Plan entity shall provide the necessary documentation to the Agency and Office upon request.

3.4 Exclusion of Benefits

A Health Flex Plan may limit or exclude benefits otherwise required by law for insurers offering coverage in the state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take any combination of those actions. A health flex plan offering may include the option of a catastrophic plan supplementing the health flex plan (s.408.909 (3), F.S.).

(a) List the benefits excluded from your Health Flex Plan that are otherwise mandated by law (Chapters 627 and 641, F.S.) by completing the following table. A more detailed description of the mandates is provided in Appendix B.

LISTING OF STATUTORY MANDATED INSURANCE AND HMO BENEFITS
PLEASE CHECK THE APPROPRIATE COLUMN

	Will be Provided in the Basic Evidence of Coverage Policy	**Will be Offered for Additional Premium**	**Will not be Offered**	**Comments**
Required Policy Benefits under the Insurance Code and HMO Statutes				
Bone Marrow Transplants				
Cancer Drugs				
Child Health Supervision Services				
Cleft Lip Palate For Children				
Dental Procedures For Children/General Anesthesia And Hospitalization				
Diabetes Treatment				
Emergency Care				
Extension of Benefits				
HIV coverage				
Home Health Care				
Mammograms				
Mastectomy/ Surgical Follow Up Care				
Maternity Care/Coverage For Post Delivery Care				
OB/GYN Annual Visit Without Prior Authorization				
Osteoporosis / Diagnosis / Treatment				

Outpatient Treatment For Services That Would Be Covered Under Inpatient Policy

TMJ/ Diagnostic and Surgical Procedures
Newborn Hearing Screening

Benefits That The Insurer Or HMO Currently Has To Offer For Additional Premium

Enteral Feeding Formulas/Treatment of PKU

Mental and Nervous Disorders

Substance Abuse
Required Payment To a Class of Providers
Acupuncture/If Policy Covers This Service
Ambulatory Surgical Center Services/ If Procedure Is Covered Under Inpatient Care

Birthing Centers And Nurse Midwives/If Maternity Care Is Provided

Chiropractor Services
Continued Coverage With Terminated Provider
Dentist Services /Surgical Services Provided in Hospital

Dermatologist/Direct Access

Massage Therapists/If Contract Provides For Massage

Nurse Anesthetist
OB/GYN
Ophthalmologist
Optometrists
Osteopaths
Osteopathic Hospital Services

Podiatrist Services
Psychotherapeutic Providers

Denial Of Coverage Due To Breast Cancer
Coverage For Adopted And Foster Children

(b) Please specify the total amount of claims paid per year (cap limits) per enrollee, if applicable. Specify any limits on enrollment, if applicable.

3.5 Notice of Denial/Nonrenewal of Coverage

Denial of coverage by a Health Flex Plan, or the nonrenewal or cancellation of coverage, must be accompanied by the specific reasons for denial, nonrenewal, or cancellation. Notice of nonrenewal or cancellation must be given at least 45 days in advance of the nonrenewal or cancellation, except that 10 days' written notice must be given for cancellation due to nonpayment of premium. If the Health Flex Plan fails to give the required notice, the health flex plan coverage must remain in effect until notice is appropriately given (s. 408.909(7), F.S.).

The applicant must comply with the provisions of this section. The application must include a listing of the reasons for denial, nonrenewal, or cancellation of coverage. The applicant must include the reasons related to nonrenewal or cancellation of coverage in all marketing materials and in each evidence of coverage policy issued (see also Subsection 6.2.3 (b)).

The Health Flex Plan entity shall provide the necessary documentation to the Agency and the Office upon request.

3.6 Retention of Records

Each Health Flex Plan shall maintain enrollment data and reasonable records of its losses, expenses, and claim experience and shall make those records reasonably available to enable the department to monitor and determine the financial viability of the Health Flex Plans, as necessary. Provider networks and total enrollment by area shall be reported to the agency biannually to enable the agency to monitor access to care (s. 408.909.(6),F.S.).

The applicant shall be responsible for submitting this information to the Agency and the Office in accordance with the timeframes specified in law. The Agency and the Office will provide the necessary forms.

3.7 Quality of Care Review Criteria

The Agency shall develop guidelines for the review of applications for Health Flex Plans and shall disapprove or withdraw approval of plans that do not meet or no longer meet minimum standards for quality of care and access. The agency shall

ensure that the health flex plans follow standardized grievance procedures similar to those required of health maintenance organizations. (s. 408.909.(3)(a), F.S.).

To ensure compliance with these provisions, the applicant shall provide the information specified below.

3.7.1 Quality Assurance Program

The Health Flex Plan entity shall ensure that the health care services provided are rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community. The applicant shall provide a detailed description of the internal quality assurance program, including a written statement of the goals and objectives related to health care outcomes, and written procedures for taking appropriate actions whenever is has been determined that substandard services have been provided, or services which should have been provided, have not been provided.

The Health Flex Plan entity shall establish a utilization review and incidence-reporting program. Documentation shall be provided to the Agency upon request.

The following incidences have to be reported to the Agency within 3 days of occurrence: death of a patient, severe brain or spinal damage, surgery performed on the wrong patient, surgical procedure performed unrelated to medical needs of a patient.

3.7.2 Specific Quality of Care Indicators

Provide a listing of quality of care indicators appropriate for the type of services provided by the Health Flex Plan.

3.7.3 Physician Credentialing/Licensing

Each entity shall maintain documentation that physicians providing services to Health Flex Plan enrollees are properly licensed by the state or credentialed. The Health Flex Plan entity shall describe the procedures to ensure that health care professionals providing services under the plan are properly licensed. Documentation demonstrating compliance with this requirement shall be made available to the Agency upon request.

3.7.4 Provider Network Adequacy

Provide a detailed description of the provider network, including specialty physicians, hospital services, ancillary services, and pharmaceutical services, as applicable to the type of Health Flex Plan proposed. Provide the criteria for selection, retention and removal of providers, and the process to initiate corrective action.

SECTION IV ACCESS TO HEALTH CARE REVIEW CRITERIA

4.1 Reasonable Access to Care

To permit the Agency to assess reasonable access to the types of services provided by the Health Flex Plan entity, the applicant shall provide minimum access standards applicable to the proposed Health Flex Plan. For each standard indicate age/sex limitations, if applicable. A description of these standards must include co-payment requirements, if applicable. These standards may include, but not be limited to:

(a) The number of primary care physicians available to the estimated number of subscribers.
(b) The number of primary care physician visits annually.
(c) The number of health care screenings by type provided annually.
(d) The number of mental health visits annually.
(e) The number of hospital days covered annually.
(f) The number of laboratory tests allowed annually by type.
(g) Waiting time for specific referrals (e.g. mammograms, x-ray, MRI, dermatologist).
(h) Other.

4.2 Grievance Process

Provide a detailed description of the internal grievance process. In addition, the Health Flex Plan coverage of evidence shall provide a member services toll-free phone number, the Office's consumer toll-free number, and the Agency's call center toll-free number. Appropriate documentation shall be made available to the Agency and the Office upon request.

4.3 Consumer Satisfaction

Any entity operating a Health Flex Plan in the state, shall conduct a biannual consumer satisfaction survey. The survey results shall be submitted to the Agency and the Office within 30 days after the data is collected.

SECTION V FINANCIAL REVIEW STANDARDS

The Office shall develop guidelines for the review of health flex plan applications and provide regulatory oversight of health flex plan advertisement and marketing procedures. The office shall disapprove or shall withdraw approval of plans that: (1) contain any ambiguous, inconsistent, or misleading provisions or any exception or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan; (2) provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentations, or that result in unfair discrimination in sales practices; or (3) cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided (s. 408.909(3)(a)(b), F.S.).

To ensure compliance with these provisions, the Office requires that the following standards be met.

5.1 Financial Solvency Requirements (Respond only to those sections applicable to your proposed plan)

5.1.1 Health Insurers and HMOs

Health Insurers and HMOs as defined in Section II of this application that are considered in good standing by the Office, are considered to meet the financial solvency standards specified in this section to offer Health Flex Plan benefits provided the coverage offered is within the scope of the benefits that the entity is authorized to offer.

5.1.2 Local Governments and Health Care Districts

Local government and health care district entities as defined in Section II of this application, have to submit documentation that they have taxing authority to support the operation of the Health Flex Plan and that they have the financial means to support the financial obligations under the Health Flex Plan and that such authority will continue as long as outstanding liabilities exist. Such entities must submit documentation that such taxing authority exists and has been authorized for this purpose. With such evidence of taxing authority, the applicant must submit a statement that the projected working capital needs and the initial expenses of the proposed Health Flex Plan are available from current accounts and general revenue sources and that such funds will be provided as needed. The plan of operation (see Section of VI of this application) must reflect that the revenue stream or financial resources available will be adequate to support the liabilities of the

plan as they are incurred and that expenses can be paid on a current basis.

Entities that provide the necessary supporting documentation, as determined by the Office, shall be considered to meet the financial solvency standards required to offer Health Flex Plan benefits.

5.1.3 Health Care Provider Sponsored Organizations and Other Public or Private Community-Based Organization, and Public/Private Partnerships.

The type of benefits offered as specified below will determine the financial requirements for these entities.

(a) Limited Health Services. If benefits offered under the Health Flex Plan are limited to selected services such as ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services, the entity must supply documentation that for the period of the program it will have, and at all times, maintain a minimum surplus in an amount which is the greater of $150,000 or 10 percent of total liabilities. "Limited health service" does not include inpatient, hospital surgical services, or emergency services except as such services are provided incidental to the limited health services. If non-incidental inpatient, hospital surgical services, or emergency services are offered, the entity must meet the requirements of item (d) of this subsection.

(b) Basic Clinic Services: If the benefits offered under the Health Flex Plan are limited to "basic clinic services" which the covered person might reasonably require to maintain good health, the entity must supply evidence that for the period of the program it will have and at all times maintain a minimum surplus in an amount which is the greater of $150,000 or 10 percent of total liabilities. "Basic services" includes any of the following: emergency care, physician care other than hospital inpatient physician services, ambulatory diagnostic treatment, and preventive health care services. However, any plan that provides or contracts for, either directly or indirectly, inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services shall not be eligible under this section and must meet the requirements required in paragraph (d) of this subsection.

(c) Limited Services and Clinic Services: If any limited health service plan, as described in paragraph (a), includes any basic clinic services as described in paragraph (b), or if any basic clinic service includes any limited health services as described in paragraph (a), the applicant must provide documentation that for the period of the duration of the plan it will have and at all times maintain a minimum surplus in an amount which is the greater of $300,000 or 10 percent of total liabilities. Any plan that

provides or contracts for, either directly or indirectly, inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services shall not be eligible under this section and must meet the requirements specified in paragraph (d) of this section.

(d) Inpatient Hospital Services, Inpatient Hospital Physician Services, or Indemnity against the Service Costs: Any entity that offers or contracts for, either directly or indirectly, services that include inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services must supply evidence that for the period of the program it will have and at all times maintain a minimum surplus in an amount which is the greater of $1,500,000 or 10 percent of total liabilities, or 2 percent of annualized premium. Entities must also prefund all startup losses, excluding profits, projected to be incurred on their startup projections until the projection reflects statutory net profits for 12 consecutive months.

5.1.4 Definition of Terms

(a) "Surplus" means the net worth of an entity as determined by statutory accounting practices; for a stock company, the sum of its capital and surplus; the amount by which the admitted assets exceed the entity's liabilities.

(b) "Statutory accounting principles and practices" means the methodology described in the National Association of Insurance Commissioners publication *Accounting Practices and Procedures Manual As of March 2004.*

(c) "Admitted Assets" are defined as those assets that meet the qualifications, limitations, and eligibility requirements, as defined in Section 641.35, Florida Statutes, and reported in accordance with the National Association of Insurance Commissioners publication *Accounting Practices and Procedures Manual As of March 2004.*

(c) "Liabilities" are defined as those as defined in Section 641.35, Florida Statutes, and reported in accordance with the National Association of Insurance Commissioners publication *Accounting Practices and Procedures Manual As of March 2004.*

5.2 Continued Demonstration of Financial Soundness Requirements

5.2.1 Health Insurers and HMOs

Entities holding a certificate of authority from the Office and a health care provider certificate from the Agency if applicable, shall continue to make

financial filings in the normal manner as required by the Florida Statutes for maintaining their certificate of authority status, and shall include with its annual and quarterly financial filings reports on Health Flex Plan enrollment data and records of its losses, expenses, and claims experience of such plans from operations in Florida on supplemental forms.

5.2.2 Local Governments or Health Care Districts.

Local government entities or health care districts that have fully assumed liability for the operation of a Health Flex Plan which is supported by the full taxing authority of the local government or health care district, shall maintain segregated records in regard to its operation of a Health Flex Plan. The annual and quarterly filings for such entities reporting the financial experience of the Health Flex Plans shall consist of the jurat page (page 1), asset page for assets allocated to the plan that are immediately available (page 2), liability page completed for line items 1 through 18 and line 21, if applicable, (page 3), the statement of revenue and expenses (page 4), Exhibit of Premiums, enrollment and utilization (page 7 of Quarterly Statement or page 34 of the Annual Statement) of the National Association of Insurance Commissioners Annual and Quarterly Health Insurance Blanks unless otherwise agreed to in writing by the Office. If the reported liabilities exceed reported assets, a statement shall be included certifying that such deficit shall be covered by tax revenue.

The annual filing shall include an actuarial certification that:

(a) The health benefit flex plan is actuarially sound, which certification shall consider the rates, benefits, and expenses of, and any other funds available for the payment of obligations of the organization.

(b) Incurred but not reported claims and claims reported but not fully paid have been adequately provided for.

(c) An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date.

5.2.3 Health Care Provider Sponsored Organization and other Public or Private Community-Based Organizations, and Public/Private Partnerships.

Such entities shall maintain segregated records in regard to their operation of a Health Flex Plan. Such entities shall make the following filings and reports:

(a) An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending

on March 31, June 30, and September 30, shall be filed within 45 days after each such date. The Office may, for good cause, grant an extension of time for filing of an annual or quarterly statement. The statements shall contain information generally included in insurers' financial statements prepared in accordance with statutory accounting principles and practices and in a form generally utilized by insurers for financial statements, sworn to by at least two executive officers of the entity. The form generally utilized by the insurers for financial statements is defined as the National Association of Insurance Commissioners Annual and Quarterly Health Insurance Blanks unless otherwise agreed to in writing by the Office.

Each entity's annual statement must contain the following:

- An audited financial statement of the organization, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant, prepared in accordance with statutory accounting principles.

  An actuarial certification that includes the following information:
  The organization is actuarially sound, which certification shall consider the rates, benefits, and expenses of, and any other funds available for the payment of obligations of the organization.
  Incurred but not reported claims, and claims reported but not fully paid have been adequately provided for.

(b) A report prepared by the certified public accountant and filed with the Office describing material weaknesses in the organization's internal control structure as noted by the certified public accountant during the audit. The report must be filed with the annual audited financial report as required in paragraph (a) of this subsection. The organization shall provide a description of remedial actions taken or proposed to correct material weaknesses, if the actions are not described in the independent certified public accountant's report.

5.3 <u>Determination that the Applicant is able to underwrite Health Care Coverage provided</u>

5.3.1 Health Insurers and HMOs

Entities holding a certificate of authority from the Florida Office of Insurance Regulation to provide health care coverage are considered to meet the requirements of this section.

5.3.2 All Other Entities

Applicants other than Health Insurers and HMOs not holding a valid certificate of authority from the Office, must demonstrate that the ownership, control, and management of the entity operating as a Health Flex Plan is competent and trustworthy and possesses managerial experience that would make the proposed organization operation beneficial to the subscribers or policyholders.

The Office shall not grant or continue authority to transact the business of a Health Flex Plan at any time during which the Office has good reason to believe that the ownership, control, or management of the organization includes any person:

(a) Who is incompetent or untrustworthy.
(b) Who is so lacking in health benefit expertise as to make the operation of the Health Flex Plan hazardous to potential and existing subscribers.
(c) Who is so lacking in health plan experience, ability, and standing as to jeopardize the reasonable promise of successful operation.
(d) Who is affiliated, directly or indirectly, through ownership, control, reinsurance transactions, or other business relations, with any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors.
(e) Whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors.
(f) Who, including any stock subscriber, stockholder, or incorporator exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the Health Flex Plan but does not possess the financial standing and business experience for the successful operation of the organization.
(g) Who, including any stock subscriber, stockholder, or incorporator, exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the Health Flex Plan, has been found guilty of, or has pled guilty or no contest to any felony or crime punishable by imprisonment of one (1) year or more under the laws of the United States or any state thereof or under the laws of any other country, which involves moral turpitude, without regard to whether a judgment or conviction has been entered by the court having jurisdiction in such case. However, in the case of an organization operating under subsisting approval, the Health Flex Plan shall remove any such person immediately upon discovery of the conditions set forth in this paragraph when applicable to such person or under the order of the Office, and the

failure to so act by the organization is grounds for revocation or suspension of the Health Flex Plan authorization.

(h) Who, including any stock subscriber, stockholder, or incorporator, exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the Health Flex Plan, is now or was in the past affiliated, directly or indirectly, through ownership interest of 10 percent or more, control, or reinsurance transactions, with any business, corporation, or other entity that has been found guilty of or has pleaded guilty or nolo contendere to any felony or crime punishable by imprisonment for one (1) year or more under the laws of the United States, any state, or any other country, regardless of adjudication.

The Health Flex Plan entity shall immediately remove such person or immediately notify the Office of such person upon discovery of the conditions set forth in this paragraph, either when applicable to such person or upon order of the Office. The failure to remove such person, provide such notice, or comply with such order constitutes grounds for suspension or revocation of the Health Flex Plan authorization.

5.4 Management and Company Information

5.4.1 Health Insurers and HMOs

Entities holding a certificate of authority from the Office of Insurance Regulation are exempt from the requirements in this section.

5.4.2 Local Government and Health Care Districts

Such entities shall identify the individuals that hold the major responsibilities for the operation of the Health Flex Plan. This would include the chief individual responsible for the plan, the chief individual responsible for handling premium receipts, the chief accounting officer of the plan, the chief individual responsible for claims payments, or the comparable persons of like position and responsibility.

5.4.3 All Other Entities

All other entities submitting an application for the operation of a Health Flex Plan shall submit the names and titles of all officers, directors of the applicant, and all shareholders (owning 10% or more of the outstanding stock of the company). An organizational chart must be provided showing all entities that exercise control over the health benefit flex plan. Companies in the organization structure from, and including, the immediate parent through the ultimate parent must provide the names and titles of all officers and directors.

5.4.4. Filing Requirements (Other than Health Insurers and HMOs)

Entities other than Health Insurers or Health Maintenance Organizations shall submit the following information:

(a) For owners, directors, or officers of the plan or in the case of a local government or health care district the individuals identified as being responsible for the health benefit flex plan, the full names and titles of all officers, directors of the applicant, and all shareholders (owning 10% or more of the outstanding stock of the company) with their respective titles and ownership information. NAMES REQUESTED IN THIS SECTION SHOULD INCLUDE FIRST, MIDDLE AND LAST NAMES (NO ABBREVIATIONS).

(b) Provide a biographical affidavit (Form OIR-C1 1423) for each officer, director, responsible person, and shareholder listed above. All questions must be answered.

The requirement for the applicant's social security number as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.072(1) and (9), Florida Statutes, social security numbers (SSN) collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 6 of the form, please include the applicant's name and social security number on a separate page and attach it to the Biographical Affidavit. Also stamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.072(9), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office. The duties of the Office in background investigation are extensive in order to insure that the owners, management, officers, and directors of any entity offering insurance are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

(c) Provide a background investigative report (see instructions, Form OIR - C1 905) for each person listed in (a) above. The report must be mailed directly to the Office from the reporting agency. Please arrange for the billing to be sent by the investigative reporting firm to the company's accounting office for payment. A listing of investigative firms is attached.

Please provide evidence indicating that investigative reports have been ordered. Evidence may include a copy of the canceled check issued to the investigative firm or a transmittal letter. It is suggested that the company order the investigative reports four weeks prior to the filing of the application with the Office of Insurance Regulation in order to expedite the application.

(d) Provide fingerprint cards (see instructions, Form OIR-C1-938) for each person listed above. The fingerprint cards and fees are due at the time the application is filed. No fingerprint cards, other than those provided by the Office with ORI number FL921400Z, are acceptable. These cards must be completed at a law enforcement agency and returned to this Office for processing. Instructions for completing the fingerprint cards are included with this package. A fee is charged for the processing of the fingerprint cards. The fingerprint cards and fees are due at the time the application is filed. Instructions for completing the fingerprint cards are included with this application.

Secure the check to the invoice (Form OIR-C1-903, included in this package) and send to:

Florida Department of Financial Services
Bureau of Financial and Support Services
Post Office Box 6100
Tallahassee, Florida 32314-6100

(e) Attach pro forma projections showing the assets, liabilities, expenses, surplus, and premium volume projected for the plan by quarter for three years.

(f) Describe the source, type and amount of funding for the initial capitalization of the plan and the contingent plan for additional funding if needed.

(g) If the organization has operations other than offering health benefit flex plans, explain how the records and operations of the health benefit flex plans will be segregated from the other operations.

(h) A comprehensive feasibility study, performed by a certified actuary in conjunction with a certified public accountant. The study shall be for the greater of 3 years or until the plan has been projected to be profitable for 12 consecutive months. The study must show that the organization would not, at the end of any month of the projection period, have less than the minimum surplus as required.

(i) Information on the organization in regard to its function, history, and experience in offering insurance or health care benefits.

(j) A copy of its corporate documents showing that it has the corporate authority to offer the plan proposed. Include a copy of evidence that the corporation is registered and in good standing with the Florida Secretary of State Office. In the case of a local government or Health Care District, attach a statement from the chief elected official or chief operating officer or attorney for that entity attesting that authority to operate a Health Flex Plan exists. Such statement shall include or be accompanied by a letter citing the legal authority to impose a tax or to use tax revenue for the purpose of offering and supporting a Health Flex Plan.

(k) A copy of the most recent independent financial audit of the organization.

(l) An organizational chart showing all related corporate entities and the ultimate controlling party.

(m) Proof of public liability insurance with proof that claims resulting from or alleged to be from medical malpractice are covered by such policies. Attach proof of fidelity coverage. A copy of the policy or binder of such insurance will be acceptable proof. In the case of a local government or Health Care District that is self insured, provide details of that plan and confirm that it extends to the health flex plan to be offered.

5.5 Subsequent Reporting Requirements for all Health Flex Plan Applicants

After obtaining approval, all entities must comply with the quarterly and annual reporting requirements outlined, and provide the following forms to the Office:

OIR-C1-1423	Biographical Affidavit
OIR-C1-938	Fingerprint Card Instructions
OIR-C1-903	Payment for Fingerprint Charges
OIR-C1-905	Instructions for Background Reports

SECTION VI FORM AND RATE REVIEW STANDARDS

The Office shall develop guidelines for the review of health flex plan applications and provide regulatory oversight of health flex plan advertisement and marketing procedures. The office shall disapprove or shall withdraw approval of plans that: (1) contain any ambiguous, inconsistent, or misleading provisions or any exception or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan; (2) provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentations, or that result in unfair discrimination in sales practices; or (3) cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided
(s. 408.909(3)(b),F.S.).

6.1 Plan of Operation

6.1.1 The applicant shall provide a Plan of Operation for the Office's review and approval. The plan of operation shall include, as a minimum:

(a) Marketing and distribution methods.

(b) Underwriting method and standards.

(c) Benefits or services to be provided and how the benefits or services will be provided or reimbursed.

(d) Identification of any entity that will provide health care or administrative services for the Health Flex Plan.

(e) The entity's plan and method of rerating. (Note: rate approval is for one year at which time rate approval expires. The rates must be submitted to the Office annually for review and approval).

6.2 Form Review

6.2. 1. The applicant shall provide for the Office's review and approval, a copy of the enrollment form that will be used by individuals seeking coverage.

The enrollment form shall:

(a) Contain the information necessary to determine the eligibility of the individual seeking coverage.
(b) Include the specific language specified in Section III, 3.3, of these application guidelines.
(c) Provide for the signature of the individual seeking coverage.

6.2.2 The applicant shall also provide for review and approval by the Office, a copy of the evidence of coverage that will be issued to individuals enrolled in the Health Flex Plan. The evidence of coverage shall include, at a minimum:

(a) The eligibility provision.

(b) The evidence of coverage detailing the contract reasons for cancellation or non-renewal. These reasons shall be limited to:

- the enrollee no longer qualifies under the eligibility standards, or
- nonpayment of premium, or

- a complete termination of Health Flex Plan business by filing entity, or
- that the pilot program was not extended.

(c) Listed and described benefits.

(d) Exclusions and limitations.

(e) Any cost sharing provisions (i.e. coinsurance, copayments, etc.) or maximum benefits (annual, lifetime, etc).

(f) The specific language specified in Section III, 3.3.

(g) A disclosure statement indicating whether or not the coverage provided constitutes "creditable coverage" under Section 627.6561, F.S. If the coverage constitutes creditable coverage, the entity shall additionally submit the form that will constitute evidence of creditable coverage upon an enrollee's termination of the plan.

(h) A detailed explanation for the position taken as to whether or not the coverage constitutes creditable coverage.

6. 3 Advertising

The following is required of all advertising materials that will be used to promote the Health Flex Plan that are disseminated in this State which the Health Flex Plan provider knows or reasonably should know is intended for presentation, distribution or dissemination in this State when such presentation, distribution or dissemination is made either directly by the Health Flex Plan or indirectly on behalf of the Health Flex Plan, by an agent, broker, producer or solicitor or any other person who has either actual or apparent authority to act on behalf of the Health Flex Plan.

6.3.1 The form and content of a Health Flex Plan advertisement shall be truthful and sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive.

6.3.2 Marketing --The following are defined as unfair methods of competition and unfair or deceptive acts or practices which may result in withdrawal of approval of plans:

(a) Misrepresentations of Health Flex Plans.-- Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:

1. Misrepresents the benefits, advantages, conditions, or terms of the Health Flex Plan.

2. Is misleading, or is a misrepresentation, as to the financial condition of the Health Flex Plan.

3. Uses any name or title or class of coverage misrepresenting the true nature thereof.

4. Is a misrepresentation for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.

5. Uses any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the sales activities of any person representing the Health Flex Plan or that the Federal Government or state guarantees any Health Flex Plan benefits.

(b) False information and advertising generally.--Knowingly making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public:

1. In a newspaper, magazine, or other publication,

2. In the form of a notice, circular, pamphlet, letter, or poster,

3. Over any radio or television station, or

4. In any other way, an unapproved advertisement, or any announcement, or statement containing any assertion, representation, or statement with respect to the Health Flex Plan, which is untrue, deceptive, or misleading.

6.4 Rate Review

6.4.1 The applicant shall provide for the Office's review and approval a rate schedule or manual.

6.4.2 To demonstrate reasonableness of premium rates, the applicant shall provide a copy of the actuarial memorandum. This memorandum must be prepared and signed by an actuary. This actuarial memorandum shall provide sufficient detail and disclosure of methods and assumptions to allow the Office to determine the reasonableness of the rates to be charged. The entity shall demonstrate a loss ratio of at least 75% or provide detailed justification why a lower loss ratio is appropriate.

The entity shall submit a certification by a qualified Actuary that to the best of the actuary's knowledge and judgment, the rate filing is based on sound actuarial principles in compliance with actuarial standards of practice, that the actuary has reviewed and considered the entities plan of operation in determining the rate schedule and that the benefits provided are reasonable in relation to the proposed premiums.

6.4.3 Plans shall not include provisions that provide benefits that are unfair or inequitable or contrary to the public policy of this state, that encourages misrepresentation, or that result in unfair discrimination in sales practices. Rating practices that are prohibited for licensed insurers or HMOs shall be considered to be in violation of this requirement.

6.5 Annual Reports

The applicant shall maintain benefit, premium and enrollment information. This data has to be provided with each year's rate filing to the Office and at any time upon request.

Actual Health Flex Plan experience shall be provided by calendar year. The information shall include at least the following information in columnar format: Year, Premium, Paid Claims, Paid Loss Ratio, Number of Enrollees, and Expenses Paid.

INVOICE
FLORIDA OFFICE OF INSURANCE REGULATION
DIVISION OF INSURER SERVICES
REQUEST FOR PAYMENT OF FINGERPRINT CHARGES

NAME OF COMPANY:_____

FEIN:_____

ADDRESS:_____

_____
CITY **STATE** **ZIP CODE**

ADDRESS (IF DIFFERENT FROM COMPANY ADDRESS)

_____

_____
CITY **STATE** **ZIP CODE**

In reference to the recent submission by the above referenced insurer regarding the fingerprint cards requested on each officer and/or director, it is necessary that this form and the fingerprint cards be returned with the proper payment as listed below for the processing of these cards.

PLEASE NOTE:

1. Send a check in the proper amount payable to the Florida Office of Financial Services and **mail check and invoice only** to the Florida Office of Financial Services, Bureau of Financial and Support Services, Post Office Box 6100, Tallahassee, Florida 32314-6100.

2. Send fingerprint cards, a **copy** of the check and a copy of the **invoice** along with the completed application package to the Florida Office of Insurance Regulation, Division of Insurer Services, Applications Section, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0332.

B/T	TY/CL	F/T
C	2002	F

FEE SCHEDULE:

Number of Cards _____ @ $64.00 per person ... $_____

($15.00 FDLE processing, $24.00 FBI processing, and $25.00 DOI processing = a total of $64.00)
Form D14-903

Fingerprints submitted on a card not provided by the Florida Department of Financial Services will not be accepted.

The enclosed fingerprint card is for your use in qualifying with the Florida Department of Financial Services. THE CARD MUST BE SIGNED BY THE APPLICANT.

FLORIDA RESIDENTS: You must take the fingerprint card to a law enforcement agency in Florida for fingerprint service. Your local sheriff, as a part of this program, will fingerprint you at no charge. There may be a charge associated with fingerprinting from another law enforcement agency.

OUT OF STATE RESIDENTS: CONSULT YOUR LOCAL LAW ENFORCEMENT AGENCIES FOR ADDITIONAL INSTRUCTIONS.

The top portion of the fingerprint card must be completed in order for FDLE and FBI to process the card. If the law enforcement agency does not fill out the top portion of the card for you, you are responsible for filling it out with all information applicable to you.

The following specific instructions should be followed:

♦ Fingers should be washed and dried thoroughly prior to prints being taken.
♦ Do not sign the fingerprint card until you are in the presence of the person who will take the fingerprints.
♦ The fingerprint card MUST be typed or filled out in BLACK INK.
♦ Your name, at the top of the fingerprint card, and all other information should be typed of printed clearly.
♦ Identity of private contractors should be shown in space "EMPLOYER AND ADDRESS".
♦ The section titled Date of Birth DOB, Place of Birth POB, SEX, HGT (height), WGT, (weight), EYES, and HAIR must all be filled out.

RACE- Use W for White, B for Black, A for Asian, I for Indian, etc. DO NOT USE THE LETTER C.

HGT- Use feet and Inches. DO NOT USE TOTAL INCHES.

EYES AND HAIR- To describe color of eyes and hair, use appropriate three letter code from the following list:

COLOR	CODE
Bald**	BAL (Hair Only)
Black	BLK (Hair Only)
Blond or Strawberry	BLN (Hair Only)
Blue	BLU (Eyes Only)
Brown	BRO
Gray or Partially Gray	GRY (Hair Only)
Green	GRN (Eyes Only)
Hazel	HAZ (Eyes Only)
Red or Auburn	RED (Hair Only)
White	WHI (Hair Only)

♦ **Bald (BAL) is to be used when the subject has lost most of the hair on top of their head.
♦ The section titled Citizenship CTZ is for your citizenship –USA, Cuba, Canada, etc.
♦ The section titled Armed Forces No. MNU is for your military service number if you have one.
♦ The section titled Social Security No. SOC is for your social security number if you have one, and it is VERY IMPORTANT. However, pursuant to section 119.072, Florida Statutes, the social security number must be collected and maintained on a separate page, see attached.
♦ You are not required to fill out the sections titled:

Your No. OCA
FBI No. FBI
Miscellaneous No. MNU

Do not fold or damage the fingerprint card in any way. The fingerprint card cannot be processed if it has been folded, erased or damaged. You may include cardboard backing to protect the fingerprint card if you like.

NOTICE: Your fingerprint card must be typed or filled out in BLACK INK. Information which has been entered on the cards may not be altered in any way, i.e., erased, covered with correction fluid or tape, marked out, etc. In addition, cards may not be folded, stapled, torn or marred in any way.

CONFIDENTIAL

Pursuant to sections 119.072(1) and (9), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution. The requirement must be relevant to the purpose for which collected and must be clearly documented. The social security numbers must be segregated on a separate page from the rest of the record.

Applicant's Name: _____
Applicant's Social Security Number: _____

The requirement for the applicant's social security is mandatory.

Section 119.072(9), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office. The duties of the Office in background investigation are extensive in order to insure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year. In establishing these qualifications and the Office's responsibility to ensure that individuals meet these qualifications, the legislature recognized that owners, officers, and directors of an insurance company are in a position to cause great harm to public should they be untrustworthy or have a criminal background. These individuals control vast amount of funds that belong to policyholders. To meet the legislative intent that these people are qualified to be trusted, having the identifying social security number is essential for the Office to adequately perform the background investigative duty. There are many individuals with the same name, without this identifying number it would be difficult if not impossible to be reasonably sure that the correct individuals are identified and verify they meet the statutorily required conditions.

CONFIDENTIAL

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

_____

_____

_____

Type of entity (i.e. insurance company, premium finance company, etc.):_ _____

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). _____

   _____

   b. Maiden Name (if applicable)._____

2. a. Have you ever had your name changed? _____ If yes, give the reason for the change and provide the full name(s).

   _____
   _____
   _____

   b. Other names used at any time (including aliases)_____

3. a. Are you a citizen of the United States?_____

   b. Are you a citizen of any other country, if so, what country?_____

4. Affiant's Occupation or Profession. _____

5. Affiant's business address.

   Business telephone.

6. Education and Training:

College/ University City/ State Dates Attended (MM/YY) Degree Obtained

_____

D14-1423

_____

Graduate Studies: College/ University City/ State Dates Attended (MM/YY) Degree Obtained

_____

Other Training: Name City/ State Dates Attended (MM/YY) Degree/Certification Obtained

_____

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information)

7 List of memberships in professional societies and associations.

_____

_____

8. Present or proposed position with the applicant entity.

- _____

9 . List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient.

_____

_____

Beginning/Ending
Dates(MM/YY)_____-Employers'Name_____

Address _____City _____State/Province _____

Country_____PostalCode_____Phone_____Offices/PositionsHeld_____

Fax_____Supervisor/Contact_____

_____

_____

Beginning/Ending
Dates(MM/YY)_____Employers'Name_____

Address _____City _____ State/Province _____

Country_____PostalCode_____Phone_____Offices/Positions Held

_____

Fax _____ Supervisor / Contact_____

_____

_____

Beginning/Ending
Dates (MM/YY) _____-_____ Employers' Name_____

Address _____City _____ State/Province _____

Country _____ Postal Code _____ Phone _____Offices/Positions Held ___

Fax _____ Supervisor / Contact _____

_____

Beginning/Ending
Dates (MM/YY) _____-_____ Employers' Name

_____

Address _____City _____

State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held ___

Fax _____Supervisor / Contact _____

_____

10 a. Have you ever been in a position which required a fidelity bond? _____ If any claims were made on the bond, give details.

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details.

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority which you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

_____

_____

Organization /Issuer of License _____ Address _____
City_____State/Province _____Country _____ Postal Code _____
License Type _____ License # _____ Date Issued (MM/YY) ___
Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

_____

_____

Organization /Issuer of License _____ Address

_____

City _____ State/Province _____ Country _____ Postal Code

_____

License Type _____ License # _____ Date Issued (MM/YY)

_____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

12 In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

_____

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

_____
_____

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

_____

Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

_____

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

_____

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sem sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

_____

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? ___

_____
_____

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

_____

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

_____
_

j. Had a lien, or foreclosure action filed against you or any entity while you were associated with that entity?

_____
_____
_____
_____

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

_____

_____

_____

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details.

14. Will you or members of your immediate family subscribe to or own, beneficially or of record, shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

_____
_____

_____
_____

If any of the shares or stock are pledged or hypothecated in any way, give details.

_____

_____

15. Have you ever been adjudged a bankrupt?

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental licensing agency? _____

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? _____

_____

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? _____

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____ at _____ I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

_____
(Signature of Affiant)

State of _____

County of _____

Personally appeared before me the above named _____ personally known to me, who, being duly sworn, deposes and says that he executed the above instrument and that the statements and answers contained therein are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me this _____day of _____ 20___.

_____
(Notary Public)

My Commission Expires _____.

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

_____

_____

_____

1. a. Affiant's Full Name (Initials Not Acceptable)._____

b. Maiden Name (if applicable)_____

2 Affiant's Social Security Number _____

3. Government Identification Number if not a U.S. Citizen _____

4. _Foreign Student ID# (if applicable)
_____

5. Date of Birth: (MM/DD/YY) _____Place of Birth: City _____

State/Province _____Country _____

6. Name of Affiant's Spouse (if applicable)
_____

7 . List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code

Dated and signed this_____day of _____ at _____

I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

_____

(Signature of Affiant)

State of _____

County of_____

Personally appeared before me the above named_____personally known to me, who, being duly sworn, deposes and says that he executed the above instrument and that the statements and answers contained therein are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me this_____day of_____20___

_____

(Notary Public)

(SEAL)

My Commission Expires

_____

AUTHORITY FOR RELEASE OF INFORMATION

To the extent permitted by law, information provided by the affiant, gathered and included in a summary background report prepared for the State Insurance Office by the Vendor shall remain confidential and shall not be subject to further disclosure under any state public records statutes.

I, **name**, presently residing at **residence address** am affiliated with or proposed to be affiliated with **Company Name** which is applying for licensure or a permit to organize with the *[State]* Department of Financial Services.

I understand that the *[State]* Office of Financial Regulation will conduct an investigation of my background. In that regard, I hereby waive any right of confidentiality as it reasonably relates to this inquiry I hereby give my permission to any court, law enforcement agency, employer, firm, or person, to disclose any knowledge and information they have concerning me which is requested by the *[State]* Department of Financial Services either directly or via a vendor *to act acting on its behalf in the capacity as described herein* and waive any provisions of law which forbids the disclosure of such information. I further consent and request that the State Department of Financial Services, its representative, or the [*Vendor*] be provided with a certified copy of any such record concerning me which they may deem necessary in the performance of their investigation. However the authorization to courts and law enforcement agencies is inapplicable to records which have been expunged in accordance with law.

I recognize the right of the *[State]* Department of Financial Services to treat at its discretion, or by operation of law, certain sources as confidential and its right to withhold from me or my agent the information identifying of such confidential sources. *However, to the extent authorized by the Fair Credit Reporting Act, I do have the right to review any information gathered in any report regarding my background and the right to dispute and submit corrections of such information as deemed appropriate*

A true copy of this Authority for Release of Information shall be valid and have the same force and effect as the signed original.

_____ Date:_____
(Signature)

This document was executed and signed in the presence of the following witnesses:

1. _____ 2. _____

State of
County of

Sworn to and subscribed before me this **Day** day of **Month** , 20 .

_____ _____
[SEAL] Notary Public

My commission Expires:
_____