FLORIDA OFFICE OF
INSURANCE REGULATION

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Insurance Commissioner

Financial Services Commission

Office of Insurance Regulation

2011 Legislative Summary

Prepared by
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OFFICE OF INSURANCE REGULATION

KEVIN M. MCCARTY
COMMISSIONER

July 2011

Dear Friends,

During the 2011 Session, the Florida Legislature passed a number of bills that will impact the Office of Insurance Regulation (Office), the insurance industry and the insurance buying public. The Office's focus in 2011 was to maintain adequate budget resources to allow us to continue our core mission and to enact regulatory reforms aimed at attracting new investment capital to our state. While we did receive personnel and budget cuts, we were able to work with the Legislature to minimize the reductions and successfully assist with the passage of priority legislation. Attached for your reference is the Office's 2011 Legislative Summary, which will provide you with a thorough review of all the major initiatives relating to insurance that passed during the session.

The Legislature undertook major property insurance reforms this year, which culminated in the passage of SB 408 by Chairman Garret Richter. This bill, which the Office supported, addresses several "cost drivers" in the property insurance market that are threatening the financial viability of many of our carriers and driving up costs for consumers. Among the various provisions of this legislation are enhanced tools for the Office to assist financially stressed insurers and new surplus requirements for property insurers doing business in Florida. SB 408 also makes comprehensive reforms to sinkhole coverage in an effort to guard against frivolous claims that increase costs to consumers.

In addition, the Legislature passed HB 1087 by Rep. Doug Holder which will expand the opportunities for international insurers to operate in Florida. Florida has a unique opportunity to attract new investors and job creators to our state by looking beyond our borders for businesses that are attracted here because of our warm climate and cultural diversity. I am pleased that the Office was able to assist in this effort by making our marketplace more attractive to these investors.

The Legislature also faced the daunting, constitutionally mandated task of balancing Florida's budget. Facing a deficit of more than $3 billion, legislators were forced to make difficult decisions about how best to meet the needs of the public but also live within budgetary restrictions. Although some initial budget allocations would have cut more than 30 positions from the Office, we worked with the Legislature to minimize these cuts in a manner that will make sure we are able to fulfill our core mission.

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The Office also worked with the Legislature to pass SB 1816 by Senators Fasano and Richter, which will benefit Florida by allowing the Office and the Chief Financial Officer to enter into agreements with other states for the allocation of revenues collected from the premium tax on surplus lines insurance policies. Florida stood to lose as much as $20 million annually in tax revenue without legislative action.

As always, the Office is committed to implementing all the regulatory changes made during the 2011 session. Although some of the laws have changed, the fundamental purpose of insurance regulation in Florida remains the same: protecting consumers, while at the same time, creating a transparent and stable regulatory environment that encourages investment in our state.

Sincerely,

Kevin M. McCarty
Commissioner

Table of Contents

FY 2011-2012 Budget Overview

2011 General Appropriations Act

SB 2000 - Approved by the Governor May 26, 2011			
Issue	**2010-2011 Funding**	**2011-2012 Funding**	**Difference Over/(Under)**
Positions	290	283	(7)
Salaries and Benefits	$18,817,425	$18,389,115	($428,310)
Other Personal Services	$150,000	$125,000	($25,000)
Expenses	$2,975,820	$2,915,820	($60,000)
Operating Capital Outlay	$2,000	$2,000	
Contracted Services	$845,726	$805,726	(40,000)
Special Categories	$4,701,763	$4,701,763	
Budget authority for financial examinations of insurance companies. Insurance companies reimburse the Insurance Regulatory Trust Fund for exam costs.			
Special Categories -	$623,512	$588,639	(34,873)
Public Hurricane Model			
Disclaimer: The Appropriations above represent funds allocated to the Office of Insurance Regulation as approved for the annual period beginning July 1, 2011 and ending June 30, 2012. The Office is funded entirely by the Insurance Regulatory Trust Fund.			

Property and Casualty

HB 99 Commercial Insurance Rates by Economic Affairs Committee; Insurance and Banking Subcommittee; Representative Drake

Amends the insurance "Rating Law," to expand the number of specified types of commercial insurance lines that are exempt from the rate filing and review requirements of Section 627.062(2)(a) and (f), F.S. Those additional lines are as follows:

- General liability insurance
- Nonresidential property insurance, except collateral protection insurance
- Nonresidential multi-peril insurance
- Excess property insurance; and
- Burglary and theft insurance

Specifies that the current statutory exemption for directors and officers, employment practices and management liability coverage is also to include fiduciary liability coverage.
Expands the commercial motor vehicle insurance coverage that is exempt from specified rate filing and review requirements to all commercial motor vehicle insurance, regardless of the size of the fleet being covered.
Requires actuarial data with regard to the rates must be maintained by the insurer or rating organization for two years, instead of the previous requirement that an insurer must keep underwriting files, premiums, losses, and expense statistics, and a rating organization must keep loss and exposure statistics applicable to loss costs.
Deletes current law which allows the Office of Insurance Regulation (Office) to require information to be submitted at the insurer's or rating organization's expense. Replaces that provision with the requirement that the insurer or rating organization must incur the cost of any examination required by the Office. Removes the requirement that insurers include the total premium written on the product during the immediately preceding year on the 30-day notice.
EFFECTIVE DATE: October 1, 2011. {Chapter Law 2011-160}

SB 408 Property and Casualty Insurance by Senators Richter and Hays

Time Limits for Claims and Statute of Limitations-

- Places time limits for bringing a hurricane or sinkhole claim. Creates a statute of limitations for bringing a breach of contract property insurance action in court;
- Claims, supplemental claims, or reopened windstorm or hurricane claims must be submitted to the insurer within three years after the hurricane first makes landfall or the windstorm causes covered damage;
- Initial, supplemental or reopened sinkhole claims must be given to the insurer within two years after the policyholder knew or reasonably should have known about the sinkhole loss;
- A five-year statute of limitations for bringing an action for the breach of a property insurance contract that runs from the date of loss was also enacted.

Florida Hurricane Catastrophe Fund-

Requires the Florida Hurricane Catastrophe Fund (FHCF) to provide reimbursement for all incurred losses, including amounts paid as fees on behalf of the policyholder. Specifies a number of losses that are excluded from payment.

Insurance Capital Build-Up Incentive Program-

Authorizes the State Board of Administration (SBA) and private market insurers to renegotiate the terms of a surplus note issued pursuant to the Insurance Capital Build-Up Incentive Program before January 1, 2011.

- If the insurer agrees to accelerate the payment period of the note by at least five years, the SBA must agree to exempt the insurer from the premium-to-surplus ratios required by statute.
- If the insurer agrees to accelerate the payment period for less than five years, the SBA may agree to an appropriate revision of the premium-to-surplus rations after consulting with the Office, subject to a minimum writing ratio of net premium to surplus of at least one to one of gross premium to surplus of at least three to one.

Surplus Requirements-

Raises the surplus requirements for insurers transacting residential property insurance that are not a wholly owned subsidiary of an insurer domiciled in another state:

- Raises the surplus requirement for new insurers from $5 million to $15 million.
- Requires an existing insurer holding a certificate of authority before July 1, 2011 to have a surplus of at least $5 million until June 30, 2016; from July 1, 2016 until June 30, 2021, a surplus of at least $10 million; and a surplus of at least $15 million on or after July 1, 2021.

Public Adjusters-

Limits public adjuster fees related to a maximum of 20 percent for:

- Reopened or supplemental claim payment;
- Claim payment made by the insurer more than one year after events declared by the Governor to be a State of Emergency.

Public adjuster fees related to a policy issued by Citizens Property Insurance Corporation (Citizens) may not exceed ten percent of the additional amount actually paid in excess of the amount originally offered by Citizens on the claim.

Prohibits public adjusters from making deceptive or misleading advertisements or solicitations. Solicitations must include a disclaimer notifying the consumer that the advertisement is a solicitation. A public adjuster contact for a property and casualty insurance claim must include the following:

- Full name of the public adjuster;
- Name of the public adjusting firm;
- Business address;
- License number;
- Other specified information.

The public adjuster must:

- Give prompt notice of property loss claim to the insurer, including in the notice the public adjuster's employment contract;
- Ensure that the insurer has access to inspect the property;
- Can interview the insured directly about the loss and claim;
- Allow the insurer to obtain information necessary to investigate and respond to the claim.

The insurance company's adjuster or persons acting on the insurer's behalf must:

- Provide at least 48 hours notice before scheduling an inspection of the property or a meeting with the insured;
- Allow the public adjuster to be present during the insurer's in-person meeting with the insured.

Requires licensed contractors to be licensed as a public adjuster in order to adjust a claim for an insured.

Rate Standards-

Requires property insurance rate filings to be submitted via the "file and use" method until May 1, 2012.

Authorizes residential property insurers to make a separate rate filing limited solely to an adjustment of its rates for reinsurance and financing products used as a replacement for reinsurance.

- The rate filing may not result in a premium increase of more than 15 percent for an individual policyholder;
- It must be approved by the Office within 45 days;
- The Office retains the authority to deny the filing if the proposed rate is excessive, inadequate, or unfairly discriminatory;
- Such filings may only be made once per 12-month period;
- Authorizes a 10 percent rate increase per policyholder that is solely based on reinsurance that replaces temporary increase in coverage limits (TICL) reinsurance from the FHCF.

Specifies that the sworn certification of a property insurance rate filing is not rendered false if the insurer provides the Office with additional information pursuant to a request from the Office. The actuary for the insurer responsible for providing the additional information must provide an additional sworn certification.

Citizens Property Insurance Corporation-

Renames the Citizens "high risk" account the "coastal" account.

Repeals the requirement to reduce the high-risk area after December 1, 2010, if necessary to reduce the probable maximum loss attributable to wind-only coverages to 25 percent below the "benchmark" for the high-risk area, which is defined in statute as the 100-year probable maximum loss for the Florida Windstorm Underwriting Association based on its November 30, 2000 exposures.

Repeals a requirement to reduce the high-risk area after February 1, 2015, by 50 percent below the benchmark.

Repeals the requirement that the Citizens board issue an annual report showing the reduction or increase in the 100-year probable maximum loss attributable to wind only coverages and the quota share program is also repealed.

Specifies that Citizens may not levy regular assessments until the full Citizens policyholder surcharge has been levied.

Specifies that the Citizens policyholder surcharge must be paid upon cancellation, termination, or renewal of an existing policy or upon issuance of every new policy issued within 12 months after the surcharge is levied or the time needed to fully collect the policyholder surcharge.

Mandates that as of January 1, 2012, Citizens must require agents to obtain from applicants for coverage a signed Acknowledgment of Potential Surcharge and Assessment Liability form.

Specifies that Citizens policies issued or renewed on or after January 1, 2012, which cover sinkhole loss may not include coverage for losses to appurtenant structures, sidewalks, decks, or patios that are caused by sinkhole activity. Citizens must exclude such coverage using a notice of coverage change, which may be included with the policy renewal.

Requires the Citizens Board of Governors to commission an independent third-party consultant with insurance company management expertise to prepare a report and make recommendations on the costs and benefits of outsourcing policy issuance and service functions to private servicing carriers. The report must be completed and submitted to the Citizens board by July 1, 2012. The board must subsequently develop a plan to implement the consultant's report and submit the plan to the Financial Services Commission (FSC) for review, modification, and approval. Upon the FSC's approval of the plan, the Citizens board must begin implementing the plan by January 1, 2013.

Specifies that members of the Citizens Board of Governors with insurance experience are deemed to be within the exception in Section 112.313(7)(b), Florida Statute, that allows a public officer to practice a particular profession or occupation when required or permitted by law or ordinance.

Provides procedures for board members who have a conflict of interest regarding a particular matter.

Notice of Cancellation-

Revises the notice of cancellation, nonrenewal or termination requirements for personal lines and commercial lines residential property insurance policies. At least 120 days notice must be given to a named insured whose residential structure has been insured by the insurer or its affiliate for at least five years.

Authorizes the nonrenewal of a policy that covers both a home and a motor vehicle for any reason applicable to either the property or motor vehicle insurance, so long as the insurer provides 90 days notice of the nonrenewal.

Reduces to 45 days the notice of cancellation requirement for a Citizens policy that has been assumed by an authorized "take out" insurer.

Authorizes an insurer to cancel or nonrenew a property insurance policy if the Office of Insurance Regulation finds that the early cancellation is necessary to protect the best interests of the public or policyholders. The Office may base its finding upon the financial condition of the insurer, the insurer's lack of adequate reinsurance coverage for hurricane risk, or other relevant factors. The nonrenewal may be conditioned upon the insurer being placed under administrative supervision or to the appointment of a receiver.

Notice of Change in Policy Terms-

Authorizes insurers to renew a property and casualty insurance policy under different policy terms by providing to the policyholder a written "Notice of Change in Policy Terms" instead of a written "Notice of Non-Renewal."

Replacement Cost Coverage-

Modifies the manner in which insurers must pay dwelling or personal property losses on a replacement cost basis.

For a dwelling loss the following changes have been made:

- The insurer must initially pay the actual cash value, minus the deductible. Subsequently the insurer must pay any amounts necessary to perform repairs as work is performed.
- If a total loss of a dwelling occurs, the insurer must pay the entire replacement cost coverage without holdback of depreciation in value pursuant to the Valued Policy Law.

For personal property losses insured on a replacement cost basis, the insurer must offer two claim payment options.

- The first option requires the insurer to pay the replacement cost without holdback of depreciation, regardless of whether the insured replaces the property.
- The second option allows the insurer to limit the initial payment to the actual cash value of the personal property to be replaced.
- To receive payment from the insurer for the full replacement value of the personal property, the insured must provide a receipt for the replaced property to the insurer.
- A policy authorizing the insurer to require replacement of personal property prior to paying the full replacement cost must provide the policyholder with a premium credit or discount and the insurer must provide clear notice of the payment process before the policy is bound.

Sinkhole and Catastrophic Ground Cover Collapse Insurance-

Authorizes insurers to restrict catastrophic ground cover collapse and sinkhole loss coverage to the principal building as defined in the insurance policy.

Allows an insurer to require a property inspection prior to issuing sinkhole loss coverage.

Clarifies that additional living expense coverage is only available pursuant to a sinkhole loss if there is structural damage to the covered building.

Changes the definition of "sinkhole loss," primarily by creating a statutory definition of "structural damage."

- A sinkhole loss is defined in statute as structural damage to the covered building, including the foundation, caused by sinkhole activity.
- The bill creates a detailed definition of "structural damage" for purposes of determining whether a sinkhole loss has occurred.
- The definition specifies five distinct types of damage that constitute structural damage.

Investigation of Sinkhole Claims –

Creates a substantially new process for an insurer's investigation of a sinkhole claim. Requires the insurer to determine whether: (1) the building has incurred structural damage that (2) has been caused by sinkhole activity. Coverage for sinkhole loss is not available if structural damage is not present or sinkhole activity is not the cause of structural damage. The new process is as follows:

- *Initial Inspection & Structural Damage Determination*: Upon receipt of a claim for sinkhole loss, the insurer must inspect the policyholder's premises to determine if there

has been structural damage which may be the result of sinkhole activity. This inspection will often require the insurer to retain a professional engineer to evaluate whether the insured building has incurred structural damage as defined by statute;

- *Sinkhole Testing Initiated by the Insurer*: The insurer is required to engage a professional engineer or professional geologist to conduct sinkhole testing pursuant to Section 627.7072, F.S., if the insurer confirms that structural damage exists and is either unable to identify a valid cause of the structural damage or discovers that the structural damage is consistent with sinkhole loss. If coverage is excluded under the policy even if sinkhole loss is confirmed, then the insurer is not required to conduct sinkhole testing;
- *Notice to the Policyholder*: The bill maintains the requirement that the insurer must provide written notice to the policyholder detailing what the insurer has determined to be the cause of damage (if the determination has been made) and a statement of the circumstances under which the insurer must conduct sinkhole testing. The policyholder must also be notified of his or her right to demand sinkhole testing and the circumstances under which the policyholder may incur costs associated with testing;
- *Authorization to Deny Sinkhole Claim*: Insurers may continue to deny the claim upon a determination that there is no sinkhole loss;
- *Policyholder Demand for Sinkhole Testing*: The bill specifies that the policyholder may demand sinkhole testing in writing within 60 days after receiving a claim denial if the insurer denies the claim without performing sinkhole testing and coverage would be available if a sinkhole loss is confirmed (i.e. the claim denial was not issued due to policy conditions or exclusions of coverage and instead was based the failure of the loss to meet the definition of sinkhole loss). However, if the policyholder requests such testing, it must pay the insurer 50 percent of the sinkhole testing costs up to $2,500. If the requested testing confirms a sinkhole loss the insurer must reimburse the testing costs to the policyholder.

Payment of Sinkhole Claims –

Maintains the requirement than an pay to stabilize the land and building and repair the foundation upon the verification of a sinkhole loss.

Provides that payment shall be made to conduct such repairs in accordance with the recommendations of the professional engineer retained by the insurer under Section 627.707(2), Florida Statute.

Provides the insurer may limit payment to the actual cash value of the sinkhole loss not including below-ground repair techniques until the policyholder enters into a contract for the performance of building stabilization repairs.

Requires the contract for below-ground repairs to be made in accordance with the recommendations set forth in the insurer's sinkhole report issued pursuant to Section 627.7073, Florida Statute, and entered into within 90 days after the policyholder receives notice that the insurer has confirmed coverage for sinkhole loss.

Stabilization and all other repairs to the structure and contents must be completed within 12 months after the policyholder enters into the contract for repairs unless the insurer and policyholder mutually agree otherwise, the claim is in litigation, or the claim is in neutral evaluation, appraisal or mediation.

Specifies that if a covered building suffers a sinkhole loss or catastrophic ground cover collapse, the insured must repair such damage in accordance with the insurer's professional engineer's recommended repairs. However, if repairs cannot be completed within policy limits, the insurer has the option to either pay to complete the recommended repairs or tender policy limits.

Prohibition Against Rebates –

Prohibits policyholders from accepting a rebate from a person performing sinkhole repairs.

Provides that if the policyholder does receive a rebate, coverage under the insurance policy is rendered void and the policyholder must refund the amount of the rebate to the insurer.

Specifies that a person who offers a rebate commits insurance fraud punishable as a third degree felony as provided in Section 775.082, Florida Statutes (up to 5 years imprisonment), Section 775.083, Florida Statutes.\ (up to a $5,000 fine), and Section 775.084, Florida Statute (for a habitual felony offender up to 10 years imprisonment with no eligibility for release for 5 years).

Nonrenewal of Policy Due to Sinkhole Claims –

Provides that a policy may only be nonrenewed if the insurer makes payments for sinkhole loss that equal or exceed policy limits for damage to the covered building or the policyholder does not repair the structure in accordance with the engineering recommendations.

Sinkhole Testing Reports –

Requires a sinkhole testing report to verify whether the structural damage to the covered building has been identified within a reasonable professional probability.

Filing of Reports with the Clerk of Courts –

Requires the insurer to also file the neutral evaluator's report (if any), a copy of the certification indicating that stabilization has been completed (if applicable), and the amount of the claim payment.

Requires the policyholder to file a copy of any sinkhole report prepared on behalf of the policyholder as a precondition to accepting a sinkhole loss payment.

Certification of Proper Completion of Sinkhole Repairs –

Provides that once building stabilization or foundation repairs of a sinkhole loss are completed, the professional engineer responsible for monitoring the repairs must issue a report to the property owner detailing the repairs performed and certifying that the repairs were performed properly.

Requires the professional engineer must file with the Clerk of Court a copy of the report and certification, the legal description of the real property, and the name of the county clerk of court.

Neutral Evaluation of Disputed Sinkhole Claims –

Specifies that neutral evaluation must determine causation (whether a sinkhole loss has occurred and, if so, whether the observed damage was caused by sinkhole activity); all methods of stabilization and repair both above and below ground; the costs for stabilization and all repairs; and all information needed to determine whether a sinkhole loss has been verified and render an opinion on all matters at dispute in the neutral evaluation.

Requires that the neutral evaluator must be allowed reasonable access to the interior and exterior of the insured structures to be evaluated or for which a claim has been made.

Requires policyholder to provide the neutral evaluator with all reports initiated on behalf of the policyholder that confirm a sinkhole loss or dispute the insurer's sinkhole testing report. Such materials must be provided prior to the neutral evaluator's physical inspection of the property.

Revises the procedures and time frames for conducting the neutral evaluation.

Provides parties 14 business days to agree to a neutral evaluator. If an agreement cannot be reached, the Department of Financial Services (DFS) shall appoint a certified neutral evaluator.

Each party may disqualify two neutral evaluators without cause; a reduction from 3 disqualifications under current law.

Provides that the neutral evaluator has 14 business days after the referral to notify the parties of the date, time and place of the neutral evaluation conference; an increase from five business days in current law.

Requires the neutral evaluator to make a reasonable effort to hold the conference within 90 days after the DFS has received the request for neutral evaluation.

Provides that failure to conduct the conference within 90 days does not invalidate either party's right to neutral evaluation.

Provides the neutral evaluator's report must be provided to the parties within 14 days after the completion of the neutral evaluation conference.

Provides that if the neutral evaluator is not qualified to determine a disputed issue, he or she may enlist the assistance of another certified neutral evaluator, a professional engineer or professional geologist who is not a certified neutral evaluator, or a licensed general contractor to provide an opinion on that issue.

Allows the neutral evaluator to request that the entity that performed the sinkhole investigation perform additional and reasonable testing that the neutral evaluator deems necessary.

If the insurer agrees to comply with the neutral evaluator's report, payments shall be made in accordance with the terms of the applicable insurance policy and Section 627.707(5), Florida Statutes.

The bill also makes the following changes related to the neutral evaluation process:

- Specifies that neutral evaluation does not invalidate an insurance policy's appraisal clause;
- Allows the parties to disqualify a neutral evaluator for cause based on specified familial or professional relationships;
- Requires admission of the neutral evaluator's oral testimony and full report in any action, litigation or proceeding related to the claim;
- Specifies that the actions of the insurer in neutral evaluation are not a confession of judgment or an admission of liability;
- Deems neutral evaluators agents of the Department of Financial Services and grants them immunity from suit pursuant to Section 44.107, Florida Statutes.

Legislative Intent –

States that the clarifications and revisions to Sections 627.706 and 627.7074, Florida Statutes, are intended to reduce the number and cost of sinkhole claims and disputes, increase reliance on scientific or technical determinations relating to sinkhole claims, and ensure that repairs are made in accordance with scientific and technical determinations and insurance claims payments.

Other Provisions-

The bill also makes the following changes:

- Repeals the consumer advocate report card for property insurers;
- Repeals an obsolete requirement that the Office develop a standard rating territory plan for residential property insurance by January 15, 2006;
- Authorizes the Public Hurricane Loss Projection Model (Public Model) to charge a private market insurer fees for use of the model related to the reasonable costs associated with the operation and maintenance of the Public Model;
- Repeals a requirement that the Office develop a method to directly correlate property insurance hurricane mitigation discounts and credits with the Uniform Home Grading Scale;
- Clarifies that the requirement that an insurer must pay a property insurance claim within 90 days of receiving notice of the claim applies to reopened and supplemental claims;
- Clarifies that inquiries about coverage on a property insurance contract are not claim activity unless a claim is filed by the policyholder which results in an insurer investigation of the claim;
- Repeals the electronic database of sinkhole activity;
- Specifies that the insurer may request at its own expense the verification a uniform hurricane mitigation verification provided to the insurer by the policyholder or policyholder's agent in addition to forms provided by an authorized mitigation inspector;
- Provides that all provisions of the act are severable from any provision that is held invalid.

EFFECTIVE DATE: Upon becoming law. {Chapter Law 2011-39}

HB 479 Medical Malpractice by Representatives Horner and Campbell

Requires that a physician, osteopathic physician, or dentist be licensed in Florida or possess an expert witness certificate issued by the Department of Health (DOH) when providing expert testimony on the current professional standard of care by a physician, osteopathic physician, or dentist.

Requires a medical malpractice insurance or self-insurance policy to state in a clear manner whether or not the insured has the exclusive right of veto of any admission of liability or offer of judgment.
Repeals the requirement that medical malpractice policies authorize the insurer to make this decision without the permission of the insured medical provider when the action is within policy limits.
Makes all evidence related to an insurer's reimbursement policies or determination regarding medical care provided to a plaintiff inadmissible.
Prohibits federal standards and regulations from being introduced into evidence in order to establish the medical provider violated the current, professional standard of care.
EFFECTIVE DATE: October 1, 2011. {Chapter Law 2011-233}

HB 723 Reciprocity of Workers' Compensation Claims by Representative Weinstein
Creates a process for reciprocity designed to ensure that if a Florida employee is injured in the course of employment while temporarily in another state, that employee is entitled to receive only the benefits required under Florida law, and not the benefits required by the other state.
Section 440.094, Florida Statutes, provides the following:

- If a Florida employee who temporarily leaves the state incidental to his or her employment and is injured in the course of employment, that employee, or beneficiaries if the injury results in death, is entitled to the benefits as if the employee were injured in Florida.
- If an employee from another state is injured incidental to employment while temporarily in Florida, that employee and his or her employer are exempt from Florida law if:
  - The employer has workers' compensation insurance coverage under its own state laws;
  - The extraterritorial provisions of Florida law are recognized in the employer's state and;
  - Employers and employees covered in Florida are exempted from the workers' compensation laws of the other state.
- The workers' compensation laws of the other state are used if an employee from the other state is injured incidental to employment while temporarily in Florida.
- A certificate from the appropriate office of another state is prima facie evidence that an employer carries workers' compensation coverage for the other state.
- The Florida court shall take judicial notice of the laws of the other state if any litigation in Florida involves a question regarding the other states construction of laws.
- The total amount of compensation derived from another jurisdiction shall be allocated against the compensation due under Florida Workers' Compensation Law when that employee has a claim under workers' compensation in the other jurisdiction for the same injury or occupational disease as filed in Florida.
- Employees are considered to be temporarily working in another state if the duration of their work does not exceed 10 consecutive days or 25 days during a calendar year.

These provisions apply to any claim made on or after July 1, 2011, regardless of the date of the accident.
EFFECTIVE DATE: July 1, 2011. {Chapter Law 2011-171}

HB 1007 Insurer Insolvency by Representatives Bernard, Julien, and Cruz
State Board of Administration-

- Allows an insurer to request that the State Board of Administration (SBA) renegotiate the terms of a surplus note issued before January 1, 2011 under the Insurance Capital Build-Up Incentive Program;
- Increases surplus requirements from $100 million to $250 million for foreign insurers to receive credit for reinsurance ceded to these foreign insurers;
- Expands the list of nationally recognized statistical rating organizations that may be utilized to provide a secure financial rating.

Title Insurers-

- Requires that the receiver shall review the condition of the title insurer and file a plan of rehabilitation for approval with the court, after an order of rehabilitation has been entered;
- Requires that policies on real property in this state issued by the title insurer in rehabilitation shall remain in force unless the receiver determines the assessment capacity provided by this section is insufficient to pay claims in the ordinary course of business;
- Allows policies on real property located outside Florida may be canceled as of a date provided by the receiver and approved by the court, if the state in which the property is located does not have statutory provisions to pay future losses on those policies;
- Requires the establishment of a claims filing deadline for policies on real property located outside Florida that have been canceled;
- Requires the receiver to establish a proposed percentage of the remaining estate assets to fund out-of-state claims when policies have been canceled, with any unused funds being returned to the general assets of the estate;
- Requires the receiver to establish a proposed percentage of the remaining estate assets to fund out-of-state claims where policies remain in force;
- Requires that funds allocated to pay claims on policies located outside of Florida shall be based on the pro rata share of premiums written in each state over each of the five calendar years preceding the date of an order of rehabilitation;
- Requires that each title insurer shall be liable for an assessment to pay all unpaid title insurance claims and expenses of administering and settling those claims on real property in this state for any title insurer that is ordered into rehabilitation;
- States the Office shall order an assessment if requested by the receiver on an annual basis in an amount that the receiver deems sufficient for the payment of known claims, loss adjustment expenses, and the cost of administration of the rehabilitation expenses.

    - The receiver shall consider the remaining assets of the insurer in receivership when making its request to the Office.
    - Annual assessments may be made until no more policies of the title insurer in rehabilitation are in force or the potential future liability has been satisfied.
    - The Office may exempt or limit the assessment of a title insurer if such assessment would result in a reduction to surplus as to policyholders below the minimum required to maintain the insurer's certificate of authority (COA) in any state.
- Requires the assessments to be based on a pro rata basis of the total direct title insurance premiums written in Florida as reported to the Office for the most recent calendar year.
- Requires assessments to be paid to the receiver within 90 days after notice of the assessment or pursuant to a quarterly installment plan approved by the receiver. Any insurer electing to pay an assessment on an installment plan must pay a finance charge, which is determined by the receiver.
- Requires the Office to order an emergency assessment when requested by the receiver. The emergency assessment cannot exceed three percent of an insurer's surplus to policyholders as of the end of the previous calendar year or more than 10 percent of its surplus to policyholders over any consecutive five year period, when added to any annual assessment in a single calendar year. The 10 percent limitation is calculated as the sum of the percentages of surplus to policyholders assessed in each of those five years.
- Allows the receiver to use the proceeds of an assessment to acquire reinsurance or otherwise provide for the assumption of policy obligations by another insurer;
- Requires the receiver to make available information regarding unpaid claims on a quarterly basis;
- Requires a title insurer in rehabilitation may not be released from rehabilitation until all of the assessed insurers have recovered the amount assessed either through surcharges collected or payments from the insurer in rehabilitation.
- Prohibits a title insurer in rehabilitation who requested an assessment from issuing new policies until the insurer has been released from rehabilitation and received approval from the Office.
- Prohibits officers, directors, and shareholders of a title insurer ordered into rehabilitation or liquidation from serving as an officer, director, or share holder of another insurer authorized in Florida unless the officer, director, or shareholder demonstrates to the Office for a two year period immediately preceding the receivership that he or she:
    - Did not contribute to the cause of the receivership through his or her actions or omissions;
    - Did not willfully violate any order of the Office;
    - Did not receive directly or indirectly any distribution of funds from the insurer in excess of amounts authorized in writing by the Office;
    - Believed the financial statements filed with the Office were true and correct statements of the title insurer's financial condition;

    - Did not engage in any business practices which were hazardous to the policyholders, creditors, or the public, and;
    - At all times acted in the best interests of the title insurer.
- Requires the Office to order a surcharge on each title insurance policy after an assessment is issued, thus insuring the interest of real property in Florida. The Office shall set the per transaction surcharge at any amount estimated to generate sufficient funds to recover the amount assessed over a period of seven years or less. The surcharge amount may not exceed $25 per transaction for each impaired title insurer. The Office can order an increase in the amount of the surcharge if additional title insurers become weakened.
- The party responsible for payment of title insurance premium is responsible for the payment of the surcharge, unless otherwise agreed between parties. No surcharge will be due or owing as to any policy of title insurance issued at the simultaneous issue rate. For everything else, the surcharge is considered a governmental assessment to be separately stated on any settlement statement. It is not subject to premium tax or reserve requirements.
- Requires a title insurer doing business in Florida, which did not write any premiums during the previous calendar year, to collect the same per transaction surcharge. The surcharge collected will be paid to the receiver within 60 days after receipt from the title agent or agency.
- The agent, agency, or direct title operation will collect the surcharge and remit them along with the policies and premiums within 60 days to the title insurer for whom the policy was written.
- Prohibits a title insurer from retaining more in surcharges for an ordered assessment than the amount of assessment the title insurer paid.
- Requires each title insurer collecting surcharges to notify the Office in a timely manner when the surcharges equal to the amount of the assessments paid has been collected. The Office then notifies all companies, including those collecting surcharges to cease collecting surcharges when notified that all assessments have been recovered.
- Requires a title insurer to provide the Office with an accounting of assessments paid and surcharges collected during the period when filing each quarterly financial statement.
- Surcharges collected in excess of the amount assessed will be paid to the Insurance Regulatory Trust Fund.

Department of Financial Services-

Allows the Department of Financial Services (DFS) to be name an ancillary receiver of a non-Florida domiciled company in order to obtain recors to adjudicate covered claims of policy holders in Florida.

Provides for the State Risk Management Trust Fund to cover employees, officers, and agents at DFS for liability relating to priority of claims paid by DFS while acting as a receiver.

Requires the Insurance Regulatory Trust Fund to cover all unreimbursed costs when opening ancillary delinquency proceedings for the purposes of obtaining records.

Clarifies the power of DFS to obtain records from third-party administrators.

Florida's Insurance Guaranty Associations

Makes changes to the Florida Insurance Guaranty Association (FIGA) and Florida Workers' Compensation Insurance Guaranty Association (FWCIGA) statutes relating to the definition of "covered claims" rejected by another state's guaranty fund.

Amends qualification of FIGA and FWCIGA board members representing, or employed by, an insurer in receivership.

Clarifies FIGA's obligation to pay valid claims after an independent review of policies and claims has been presented.

EFFECTIVE DATE: July 1, 2011. {Chapter Law 2011-226}

HB 1087 Insurance by Representative Holder

Named Insured to First-Named Insured

Changes the designated person an insurer is required to notify from the "named insured" to the "first-named insured" in the nonrenewal, renewal or cancellation of the following type policies:

- Workers' Compensation
- Employer Liability
- Commercial Liability
- Motor Vehicle
- Other forms of Property and Casualty Insurance

Workers' Compensation

Allows the use of a prepaid card to be issued to an injured employee under the provision of workers' compensation if certain criteria are met.

Gives the insurers flexibility regarding the frequency of premium audits by providing such audits are required for coverage, except as:

- Afforded by the insurance policy;
- By an order of the Office;
- Or once each policy period at the request of the insured.

Provides assessments for the Special Disability Trust Fund are based on a calendar year.

Certificate of Authority Requirements for Insurers-

Allows insurers domiciled outside the United States, that only cover nonresidents of the United States, to be exempt from the certificate of authority (COA) provisions if certain criteria are met.

Service Warranty Associations

Exempts service warranty companies, who only offer, market, or sell service warranties to nonresidents of Florida and meet certain requirements, from licensure requirements.

Surplus Lines Insurance

- Allows surplus lines insurance agents to place commercial insurance directly in the surplus lines market.
- Does not require the agent to search for coverage from an authorized insurer.
- Requires the insured to sign a disclosure regarding surplus lines coverage.

EFFECTIVE DATE: Section 20 of this bill takes effect upon becoming law; otherwise, this bill takes effect July 1, 2011. {Chapter Law 2011-174}

SB 1816 Surplus Lines Insurance by Senators Fasano and Richter

- Applies surplus lines tax to the entire premium of a surplus lines policy covering risks over multiple states when Florida is the home state of the insured as determined by the Nonadmitted and Reinsurance Reform Act of 2010 (NRRA);
- Authorizes the Office and DFS to enter into cooperative reciprocal agreements with other states to collect and allocate nonadmitted surplus lines insurance taxes for multi-state risks;
- Authorizes the creation of a clearinghouse to receive the surplus lines premium tax collected by the home state of the insured and disburse the appropriate tax amount to the states where the risks are located;
- Authorizes the clearinghouse to collect a service fee of 0.3 percent of the gross premium.
- Limits the tax rate collected on a multi-state surplus lines policies where the insured risk is located;
- Authorizes the Legislature to review any such agreement;
- Authorizes the Legislature to instruct the Chief Financial Officer (CFO) of the DFS to withdraw from an agreement if it determines the agreement is not in the best interest of the state;
- Requires DFS to issue a report to the Senate President and Speaker of the House of Representatives about the terms and conditions of the agreement;
- Creates requirements governing the reporting and payment of surplus lines premium tax revenue and fees for policies covering multi-state risks;
- Gives surplus lines agents and insured that do not use a surplus lines agent to procure coverage, 45 days after the end of the calendar quarter to file an affidavit describing the transactions handled during the last quarter and pay the required premium.

EFFECTIVE DATE: Upon becoming law. {Chapter Law 2011-46}

HB 4081 Repeal of Obsolete Insurance Provisions by Representative Horner

Repeals the following:

- Section 215.5595(11), Florida Statutes – Removing outdated or obsolete language relating to a refund to Citizens Property Insurance Corporation (Citizens) of funds not committed or reserved for insurers in the Insurance Capital Build-Up Incentive Program (Program);
- Section 627.311(3)(k)2, Florida Statutes – Removing requirements of pre-suit notice for suits brought against the Florida Automobile Joint Underwriting Association (FAJUA);
- Section 627.706(3), Florida Statutes – Iliminating form filings for compliance with the mandatory catastrophic ground cover collapse coverage;

- Section 627.7065(5), Florida Statutes – Deleting the requirement of submitting a report on the development of a sinkhole database;
- Section 627.7077, Florida Statutes – Deleting the requirement of a feasibility study for Florida sinkhole coverage facility; and,
- Section 627.712(7), Florida Statutes – Removing the effective date of insurers' mandatory windstorm and contents coverage in property insurance policies.

EFFECTIVE DATE: July 1, 2011. {Chapter Law 2011-11}

HB 4181 Prohibited Activities of Citizens Property Insurance Corporation

Repeals Section 215.55951, Florida Statutes, which prohibited Citizens from justifying a rate or assessment increase based on amendments enacted in Chapter 2008-66, Laws of Florida, to the Insurance Capital Build-Up Incentive Program.

EFFECTIVE DATE: July 1, 2011. {Chapter Law 2011-13}

Life and Health

HB 445 Wellness or Health Improvement Programs by Representative Ingram

Specifies an insurer or health maintenance organization (HMO) that issues a group or individual health benefit plan may offer a voluntary wellness or health improvement program. Also specifies that an insurer or HMO may encourage participation in the program by offering rewards or incentives. The rewards or incentives can include, but are not limited to:

- Merchandise
- Gift Cards
- Debit Cards
- Premium Discounts
- Contributions to a health savings account
- Copayment, Deductible, or Coinsurance modification

Authorizes insurers and HMOs to require plan members to verify that the medical history can limit participation in the program in regards to receiving rewards or incentives.
Requires the reward or incentive to be disclosed in the insurance policy or certificate.
EFFECTIVE DATE: July 1, 2011. {Chapter Law 2011-167}

HB 1037 Continuing Care Retirement Communities by Representatives Bembery and Passidomo

Authorizes the use of continuing care at-home (CCAH) contracts in order to allow individuals to receive services offered by a continuing care retirement community (CCRC) in their own home while reserving the right to shelter to be provided by the CCRC at a later date.
Defines "continuing care at-home" to mean "pursuant to a contract other than a contract described in subsection (2) [relating to continuing care], furnishing to a resident who resides outside the facility the right to future access to shelter and nursing care or personal services, whether such services are provided in the facility or in another setting designated in the contract, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee."
Creates Section 651.057, Florida Statutes, to govern CCAH contracts and provides requirements for providers that offer CCAH contracts.
Amends Section 651.021, Florida Statutes, to require written approval from the Office of Insurance Regulation (Office) before constructing a new facility or marketing the expansion of an existing facility equivalent to the addition of at least 20 percent of existing units or 20 percent or more in the number of CCAH contracts.
Amends Section 651.023, Florida Statutes, providing if a feasibility study is prepared by an independent certified public accountant, it must contain an examination opinion for the first three years of operation and financial projections having a compilation opinion for the next three years. A feasibility study prepared by an independent actuary consultant must contain mortality and morbidity data, as well as an actuary's signed opinion that the project as proposed is feasible and the study was prepared pursuant to standards adopted by the American Academy of Actuaries.
A certificate of authority (COA) will not be issued until the CCRC project has a minimum of 50 percent of the units reserved and provided proof to the Office. A provider offering CCAH

contracts who applies for a COA or approval of an expansion must independently meet the same minimum requirements for the continuing care and CCAH contracts.
Provides that for an expansion of CCRC or CCAH contracts, a minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee for CCRC and 50 percent of the moneys paid for all or any part of the initial fee collected for CCAH will be placed in an escrow if, among other things, the consultant who prepared the feasibility study (or an approved substitute) certifies within 12 months before the date of filing for Office approval that there has been no material adverse change in status with regard to study.
Amends Section 651.055, Florida Statutes, which:

- Provides that a prospective resident, resident, or resident's estate is not entitled to interest of any kind on a deposit or entrance fee unless specifically provided for in the contract by amending Section 651.055, Florida Statutes;
- Permits contracts for continuing care and CCAH to include agreements to provide care for any duration;
- Requires a provider to file a new residency contract for approval within 30 days after receipt of a letter from the Office, which notifies the provider of a noncompliant residency contract; and,
- Provides the provider may continue to use the previously approved residency contract pending review and approval of the new contract.

Amends Section 651.118, Florida Statutes to provide that the Agency for Health Care Administration (AHCA) does not need to approve sheltered nursing home beds for the residences of residents living outside the facility pursuant to a CCAH contract.
EFFECTIVE DATE: July 1, 2011. {Chapter Law 2011-193}

HB 1125 Health and Human Services by Representative Corcoran
Florida Health Choices Program-
Makes the following changes to the Florida Health Choices Program (program):

- Expands the products, vendors, employers, and individuals that participate in the program;
- Streamlines and clarifies the process for approving and offering new products;
- Requires the Office to approve risk-bearing products offered by the program.

Other Provisions-

- Exempts specified Medicaid psychiatric facilities and Level III neonatal intensive care units from the certificate-of-need provisions when certain criteria are met;
- Eliminates the requirement that an enrollee must be 64 years of age or younger from health flex plans;
- Adds orthotists and prosthetists who are licensed to the definition of "health care provider" under Section 766.202, Florida Statutes.

EFFECTIVE DATE: July 1, 2011. {Chapter Law 2011-195}

HB 1193 Health Insurance by Representative Hudson

Provides a person may not be compelled to purchase health insurance, except as a condition of:

- Employment;
- Voluntary participation in a state or local benefit;
- Operating dangerous equipment;
- Occupations that have risk of injury or illness;
- Court ordered as a condition of child support; or
- Between private persons.

Provides this would not prohibit the collection of debts lawfully incurred for health insurance.
EFFECTIVE DATE: Upon becoming law. {Chapter Law 2011-126}

Medicaid Reform

SB 2144 Medicaid by Budget Committee

- Prepaid Limited Health Service Organizations (PLHSOs) licensed under Chapter 636, Florida Statutes: Exempts from Insurance Premiums Tax the premiums, contributions, and assessments received under a contract with Medicaid to solely provide services to Medicaid recipients.
- The exemptions will operate prospectively and does not provide a basis for an assessment of taxes not paid, or a basis for determining any right to a refund of taxes paid, prior to the effective date.

EFFECTIVE DATE: July 1, 2011. {Chapter Law 2011-61}

HB 7107 Medicaid Managed Care by Representative Schenck

Establishes the Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. The State will apply for federal waivers as necessary to implement the legislation. All Medicaid recipients will be enrolled in managed care plans unless specifically exempt. Recipients who are exempted include persons with limited eligibility or benefits and persons with developmental disabilities.

Other than conforming cross references, there were no amendments to Florida's Insurance Code. However, for insurers, HMOs, and other regulated entities that contract with the Florida Medicaid Program, the Office would note:

A variety of managed care plans may participate in the State's managed care Medicaid program. The following provisions include, but are not limited to, changes that would affect companies under contract with Florida Medicaid:

- Plans will compete for Medicaid contracts via an invitation-to-negotiate process based on specified qualifications, such as price, provider network adequacy, accreditation, community partnerships, additional benefit offerings, and performance history.
- There will be a limited number of plans in each of eleven regions to promote plan stability but also provide choices to recipients.
- Insurers and HMOs will be prepaid on a full-risk basis via a monthly capitated rate designed to represent the costs needed to provide all medically necessary services in the aggregate during any month-long period.
- Capitation rates will be risk-adjusted based on patient encounter data.
- Risk-adjusted rates will ensure plans are paid more for sicker patients in order to allocate resources appropriately.
- Limits will be placed on how much profit can be earned by managed care plans to ensure that plans are not overspending on administration or earning profit at the expense of patient care.
- The system of "achieved savings rebates" will require plans that exceed an appropriate profit threshold to pay dollars back to the state, thereby eliminating an incentive to withhold appropriate spending on health care services:
    - Administrative fees are restricted to actuarially appropriate levels.
    - Effective management of care will achieve savings that will be shared with the state.

- Plans may retain a reasonable profit of up to a 5 percent margin. Plans must pay back a portion of profits above that threshold and must pay back all profits above a 10 percent margin.
- Plans can earn an additional one percent profit if they demonstrate exceptional performance.
- Plans will be required to perform and submit detailed audits to verify the achieved savings rebates.

EFFECTIVE DATE: July 1, 2011. {Chapter Law 2011-134}

HB 7109 Medicaid by Representative Schenck

Designed to conform certain provisions of existing Medicaid law to HB 7107 (see above) and further authorizes a number of immediate changes to the Medicaid program.
The provisions of the legislation of note for plans/products regulated by the Office include, but are not limited to:

Provider Service Networks (PSNs)-

- A prepaid PSN that applies for and obtains a health care provider certificate from AHCA, may obtain a certificate of authority under the Insurance Code relating to HMOs
- A PSN will be required to
  - meet the surplus requirements for health maintenance organizations (HMOs) under the Insurance Code, and
  - meet all other applicable requirements relating to the regulation of health maintenance organizations (HMOs)
- A certified PSN is granted the same rights and responsibilities as a certified HMO.
- Creates an exception in the Insurance Code's solvency requirements for PSNs to specify that a PSN seeking a certificate of authority (COA) must meet the bill's surplus requirements instead of those under existing law.
- PSNs may still be fee-for-service for a period of time, but specific requirements are established for shared savings and guidelines are defined for a reconciliation process that determines shared savings.

Tort Reform-

Encourages greater participation by medical practitioners in the Medicaid program by creating limitations on noneconomic damages for negligence of a practitioner providing services and care to a Medicaid recipient.

- Noneconomic damages may not exceed $300, 000 per claimant unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner, defined as acting in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.
- An individual practitioner is not liable for more than $200,000 in noneconomic damages, regardless of the number of claimants, unless a claimant pleads and proves, by clear and convincing evidence that the practitioner acted in a wrongful manner.
- For the bill's limitations on noneconomic damages, the term "practitioner," in addition to practitioners included in the definition under s. 766.118(1), F.S., includes hospitals, ambulatory surgical centers, and mobile surgical facilities.

Medicaid Managed Care -

- AHCA is required to develop uniform accounting and reporting requirements for Medicaid managed care plans.
- Plans must begin reporting their medical and non-medical costs to AHCA.
- This information must be made public and will help ensure that plans are providing adequately managed, patient-centered care.
- Plans will be given advance notice and an opportunity to comment on any potential rate adjustments.
- AHCA will perform a simulated rate-setting exercise prior to making rate adjustments, the results of which must be posted on AHCA's website for 45 days.

Other Provisions within this legislation-

- AHCA is directed to develop a process to enable a recipient with access to employer-sponsored coverage to opt-out of all Medicaid managed care plans and use Medicaid financial assistance to pay the recipient's share of the cost for the employer-sponsored coverage.
- AHCA is also directed to seek federal approval to enable recipients with access to other insurance or related products that provide access to health care services, including products available under the Florida Health Choices program or any health exchange, to opt-out.
- The amount of financial assistance provided for any such recipient may not exceed the amount the Medicaid program would have paid to a Medicaid managed care plan for that recipient.

AHCA Reorganization-

- AHCA is directed to develop a reorganization plan for realignment of administrative resources of the Medicaid program to respond to changes in functional responsibilities and priorities necessary for implementation of HB 7107.
- The reorganization plan must assess AHCA's current capabilities, identify shifts in staffing and other resources necessary to strengthen procurement and contract monitoring functions, and establish an implementation timeline.
- The plan must be submitted to the Governor, the Speaker of the House of Representatives, and the President of the Senate by August 1, 2011.

EFFECTIVE DATE: Upon becoming law, except for the provisions taking effect on July 1, 2011. {Chapter Law 2011-135}

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