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I. Regulatory Awareness

Overview and Learning Objective

Insurance is a highly regulated industry. It is regulated to protect the public interest and to make sure insurance is available on an equitable basis. Regulation of the insurance industry is undertaken from several perspectives and is divided among a number of authorities (entities). In the State of Florida, the Department of Financial Services (DFS) and the Office of Insurance Regulation (OIR) each play a major role in regulating the insurance industry. The DFS is primarily responsible for regulating agents, combating insurance fraud, and protecting consumers, while the OIR is responsible for overseeing the conduct and licensing of insurance companies. In addition, the Office of Financial Regulation (OFR) is responsible for administering the state’s banking and securities laws. If you combine all of these entities, DFS, OIR and OFR, they ensure that agents and agencies, and insurers are licensed properly and conduct insurance business in accordance with the Florida Insurance Code.

In this course, agents will learn about appointment procedures, continuing education requirements, recordkeeping requirements, and advertising rules that apply to agents, as well as the penalties for noncompliance. They will also gain an understanding of the role and responsibilities of the Florida Life and Health Insurance Guaranty Association (FLHIGA), as well as the Florida Insurance Guaranty Association (FIGA). Throughout this course, examples are given using actual cases and investigations.

A. Jurisdiction of duties and responsibilities

The Financial Services Commission

The Financial Insurance Commission is comprised of four members:

- the Governor,
- the Attorney General,
- the Chief Financial Officer and
- the Commissioner of Agriculture.

The two offices within the Commission are the Office of Financial Regulation (OFR), which regulates the banking, finance and securities industries in Florida, and the Office of Insurance Regulation (OIR), which regulates insurance companies. Both offices are headed by commissioners who are appointed by the Financial Services Commission. The Financial Services Commission is responsible for final approval of rules developed by each office. All regulatory decisions are vested with the offices. Financial Services Commission (Members: Governor, Attorney General, Chief Financial Officer, and the Commissioner of Agriculture) Office of Financial Regulation (OFR) Office of Insurance Regulation (OIR). Let’s review each of these two offices, the Office of Financial Regulation and the Office of Insurance Regulation in greater detail.

1. Chief Financial Officer (CFO)
According to F.S. Chapter 17, the **Chief Financial Officer (CFO)** of Florida is a statewide elected official and officer of the Florida Cabinet who is elected to a four-year term. The office was created in 2002 following the reorganization of the Florida Cabinet back in 1998 which combined the former offices of the Comptroller, Treasurer, Insurance Commissioner and Fire Marshal.

The CFO is the chief fiscal officer of the state and heads the Florida Department of Financial Services. The CFO is responsible for overseeing the state's finances, collecting revenue, paying state bills, auditing state agencies, regulating cemeteries and funerals, handling fires and arsons.

### ii. Department of Financial Services (DFS)

**Jurisdiction and Duties of the Department of Financial Services (DFS)**

According to F.S. § 20.121(1) and F.S. § 20.121(2), the **Florida Department of Financial Services**, hereinafter referred to as the DFS, is a state agency headquartered in Tallahassee. In 1988, as recommended by the Constitutional Revision Commission, and passed into law by voters, the Florida Legislature carried out an amendment to the state’s constitution by merging the Department of Insurance, Treasury, State Fire Marshal and the Department of Banking and Finance into the DFS effective January 2003.

The DFS regulates the state’s banking, securities, insurance, mortgage lending and funeral and cemetery businesses. The DFS is comprised of the following 14 divisions which are required to carry out the statutory duties of the state of Florida. They are:

- Accounting and Auditing
- Consumer Services
- Funeral, Cemetery, and Consumer Services
- Insurance Agent and Agency Services
- Insurance Fraud
- Public Assistance Fraud
- Rehabilitation and Liquidation
- Risk Management
- Treasury
- State Fire Marshal
- Workers’ Compensation

Support Divisions include the following:

- Administration
- Information Systems
- Legal Services

Several of these divisions have a role in regulating insurance including the Divisions of Agents and Agency Services, Insurance Fraud, and Consumer Services.

- **Agents and Agency Services** – regulates the licensing of individuals and entities that transact insurance business in the state of Florida. The Bureau of Licensing and the Bureau of Investigations are located with
this division: The Licensing Bureau ensures that licenses are issued only to individuals who meet the state’s licensing requirements, while the Bureau of Investigations investigates possible violations of the Florida Insurance Code.

- **Insurance Fraud** – a law enforcement agency that protects Florida citizens and businesses from all types of financial and insurance fraud, including claims fraud, workers’ compensation fraud, unauthorized insurance entity fraud, and insurance agent crimes, along with viatical application fraud. The Division of Insurance Fraud also issues public information announcements and provides training for insurers to help prevent and fight fraud.

- **Consumer Services** – provides information and educational materials to consumers to help them make informed insurance and financial decisions. Consumers can contact this division’s insurance specialist with insurance-related questions and to request consumer guides about topics such as buying annuities, shopping for mortgages, purchasing long-term care and health insurance, and dealing with debt collectors.

iii. **Office of Insurance Regulation (OIR)**

The OIR has responsibility for the regulation, compliance and enforcement of statutes related to insurance and the monitoring of industry markets. These regulatory functions are performed primarily through the units listed below.

The OIR regulates and provides oversight for all insurance companies and insurance-related entities licensed to do business in Florida as described above. Additionally, the OIR provides oversight to all residual markets and joint underwriting associations, which were created by the Legislature to provide insurance to consumers who are unable to obtain coverage in the private market. Examples of these entities include the Florida Patients’ Compensation Fund and the Florida Automobile Joint Underwriting Association.

- **Company Admissions Section** – receives company applications and coordinates the review of these applications to determine whether to license companies to sell insurance in Florida.

- **Life and Health Financial Oversight Unit** - monitors the solvency of life and health insurers by obtaining and reviewing periodic financial statements. The unit also monitors the financial condition of managed care entities by conducting actuarial reviews and field examinations and analyzing financial statements. Life and Health Product Review Unit which reviews and approves health insurance rates and life and health policies that are to be issued to Florida residents.

- **Market Investigations Unit** - examines and investigates business practices and alleged violations of the Florida Insurance Code.

- **Market Research and Technology Unit** - collects and distributes information and resource materials relating to the oversight and development of Florida’s insurance markets. The unit also provides analysis and discussion at both the national and international levels regarding insurance issues important to Florida. Property and Casualty Financial Oversight Unit which monitors the financial stability of insurers by obtaining and reviewing financial statements and conducting on-site financial examinations.

- **Property and Casualty Product Review Unit** - reviews property and casualty rules, forms, and rate filings for homeowners, auto, workers’ compensation, liability, and other personal and commercial property and casualty lines of coverage to ensure compliance with the Florida Insurance Code.

- **Specialty Product Administration Unit** - provides regulation and oversight to insurance administrators, continuing care retirement communities, motor vehicle service agreement companies, home warranty associations, service warranty associations, insurance premium finance companies, donor annuities, legal expense corporations, viatical settlement providers, third party administrators, and title insurance agents and insurers. The unit licenses and monitors the quality of
company assets, adequacy of stated liabilities, general operating results and market conduct of these entities to assure compliance with the Florida Insurance Code. The OIR regulates and provides oversight for all insurance companies and insurance related entities licensed to do business in Florida as described above. Additionally, the OIR provides oversight to all residual markets and joint underwriting associations, which were created by the Legislature to provide insurance to consumers who are unable to obtain coverage in the private market. Examples of these entities include the Florida Patients Compensation Fund and the Florida Automobile Joint Underwriting Association.

iv. Office of Financial Regulation (OFR)

Office of Financial Regulation (OFR)

According to F.S. § 20.121(3)(a)2, the mission of the Office of Financial Regulation (OFR), is to protect the citizens of Florida by carrying out the banking, securities, and financial laws of the state efficiently and effectively, and to provide regulation of businesses that promote the sound growth and development of Florida’s economy.

The OFR was created in 2003 as the result of the Cabinet Reorganization Act of 2002. Although the OFR is a relatively new agency, it began as a banking, consumer finance, and securities regulator back in the mid-1800s with the creation of the former Comptroller’s Office. The OFR reports to the Financial Services Commission. The head of the OIR is the Commissioner of Insurance Regulation.

The OFR reviews consumer complaints involving illegal financial activities, reviews business applications to conduct financial services, and reviews individual license applications and may impose licensing restrictions or denial of licensure. The OFR may conduct financial investigations into allegations of suspected illegal activities within its jurisdiction.

The OFR performs these functions through four divisions. They are:

- **Consumer Finance** - The Division of Consumer Finance licenses and regulates non-depository financial service industries and individuals and conducts examinations and complaint investigations for licensed entities to determine compliance with Florida law.
- **Financial Institutions** - The Division of Financial Institutions ensures that each state-chartered financial institution meets state and federal requirements for safety and soundness.
- **Securities** - The Division of Securities regulates the sale of securities in, to or from Florida by firms (securities dealers, issuer dealers and investment advisers), branch offices and individuals affiliated with these firms to determine compliance with Florida law; and
- **Bureau of Financial Investigations** - The Bureau of Financial Investigations (Bureau) is a criminal justice agency with investigative teams located in Tallahassee, Orlando, Tampa, West Palm Beach and Miami. The Bureau generally conducts complex investigations involving securities and mortgage fraud. Cases are prioritized and resources are typically devoted to matters that significantly impact the citizens of Florida. The Bureau also participates in joint investigations with local, state and federal law enforcement agencies. The head of the OFR is the Director, who may also be known as the Commissioner of Financial Regulation. For additional information about the OFR you can view OFR Fast Facts at: http://www.flofr.com/staticpages/documents/ofrfastfactsebooklet.pdf
- **Office of Insurance Regulation** - According to F.S. 20.121(3)(a)1, the Office of Insurance Regulation (OIR) ensures that insurance companies licensed to do business in Florida are financially viable, operating with the laws and regulations governing the industry, and offering insurance policy products at fair and adequate rates that do not unfairly discriminate against the public. The OIR has responsibility for the regulation, compliance and enforcement of statutes related to insurance and the monitoring of industry
markets. These regulatory functions are performed primarily through the units listed below. Company Admissions Section which receives company applications and coordinates the review of these applications to determine whether to license companies to sell insurance in Florida.

The head of the OFR is the Director, who may also be known as the Commissioner of Financial Regulation. For additional information about the OFR you can view OFR Fast Facts at: http://www.flofr.com/StaticPages/documents/OFRFastFactsebooklet.pdf

**Fees** - According to 69B-211.005 F.A.C., the DFS is authorized to charge certain fees payable by applicants and others, in amounts sufficient to cover the actual cost of the service provided. The DFS has determined the costs of the following services:

- Fingerprint processing fee for each fingerprint card submitted $64
- Exam fee for each exam scheduled $56

The fees listed in subsection above, will be made payable to the “Florida Department of Financial Services.” The fees are payable in advance of the service provided and are not refundable.

**Effective Date of Termination of Appointment** - According to 69B-211.007 F.A.C., when an appointing entity terminates the appointment of an appointee and files written notice of such termination with the DFS the DFS must terminate the appointment. The date of such termination on DFS records will be the effective date of such termination as indicated by the appointing entity in its filing with the DFS or, if no date is indicated, the date on which the DFS received the filing.

**B. Licensing requirements**

Licensing insurance producers and insurers helps protect the insurance consumer and allows the state’s Insurance Departments to maintain standards of uniformity. By licensing individual insurance producers and insurers, the state can provide some level of assurance to the consumer that their needs will be met by an individual capable of offering guidance and competency and be protected by a regulated insurer.

**Background**

Insurance producers must be licensed properly to sell insurance in the jurisdictions where they conduct business. A resident license is required for selling within the state where the producer resides; should a producer sell in another state, he or she must obtain a nonresident license to do so. The sale of products other than property and casualty insurance, such as life insurance or investments, also requires a separate license. It is the responsibility of every insurance producer to comply fully with the state regulations regarding their licensing requirements for all activities in which he or she engages.

**Application for License** - According to F.S. § 626.171, the DFS will not issue a license to anyone except when an application filed with the DFS, meeting the qualifications for the license applied for, and payment in advance of all applicable fees. The application must be made under the oath of the applicant and be signed by the applicant.

An applicant may permit a third party to complete, submit, and sign an application on the applicant’s behalf, but is responsible for ensuring that the information on the application is true and correct and is accountable for any misstatements or misrepresentations. The DFS may accept the uniform application for nonresident agent licensing.
Qualifications for License - According to F.S. § 626.785, the DFS will not grant or issue a license as life agent to any individual found to be untrustworthy or incompetent, or who does not meet the following qualifications:

- Must be a natural person of at least 18 years of age.
- Must be a United States citizen or legal alien who possesses work authorization from the United States Bureau of Citizenship and Immigration Services and a bona fide resident of this state.
- Must not be an employee of the United States Department of Veterans Affairs or state service office.
- Must not be a funeral director, direct disposer, employee or representative, have an office in, or in connection with, a funeral establishment, except that a funeral establishment may contract with a life insurance agent to sell a preneed contract. Excluding other provisions of this chapter, an agent may sell limited policies of insurance covering the expense of final disposition or burial of an insured in the amount of $12,500, plus an annual percentage increase based on the Annual Consumer Price Index compiled by the United States Department of Labor, beginning with the Annual Consumer Price Index announced by the United States Department of Labor for the year 2003.
- Must take and pass any examination for license required.
- Must be qualified in knowledge, experience, or instruction in the business of insurance and meet all other requirements.

i. Appointment

Appointment - According to F.S. § 626.112, no person may be, act as, advertise, or act as an insurance agent, insurance adjuster, or customer representative unless he or she is currently licensed by the DFS and appointed by an appropriate appointing entity or person.

All applicants must be submitted electronically through eAppoint, the state’s electronic appointment system that is used for original and renewal appointments as well as appointment terminations.

Payment of Fees and Taxes - According to F.S. § 626.371, all initial appointments must be submitted to the DFS on a monthly basis no later than 45 days after the date of appointment and becomes effective on the date requested on the appointment form.

Failure to notify the DFS within the required time period will result in the appointing entity being assessed a delinquent fee of $250 per appointee. Delinquent fees must be paid by the appointing entity and may not be charged to the appointee. Failure to timely renew an appointment by an appointing entity prior to the expiration date of the appointment will result in the appointing entity being assessed late filing, continuation, and reinstatement fees. Such fees must be paid by the appointing entity and cannot be charged back to the appointee.

Reasons for Termination - According to F.S. 626.441, any insurer terminating the appointment of an agent; any general lines agent terminating the appointment of a customer representative or a crop hail or multiple-peril crop insurance agent; and any employer terminating the appointment of an adjuster, service representative, or managing general agent, whether such termination is by direct action of the appointing insurer, agent, or employer or by failure to renew or continue the appointment as provided, must file with the DFS a statement of the reasons, if any, for and the facts relative to such termination. In the case of termination of the appointment of an agent, such information may be filed by the insurer or by the general agent of the insurer. In the case of terminations by failure to renew or continue the appointment, the information required must be filed with the DFS as soon as possible, and at all events within 30 days, after the date notice of intention not to so renew or continue was filed with the DFS. In all other cases, the information required will be filed with the DFS at the time, or at all events within 10 days after, notice of the termination was filed with the DFS. Procedure for Refusal, Suspension.
Appointment Renewal Notification and Termination - According to F.S. § 626.381, the appointment of an appointee will continue in force until suspended, revoked, or otherwise terminated, but subject to a renewal request filed by the appointing entity in the appointee’s birth month as to natural persons or license date as to entities and every 24 months thereafter, accompanied by payment of the renewal appointment fee and taxes.

Each appointing entity must file with the DFS the lists, statements, and information as to appointees whose appointments are being renewed or terminated, accompanied by payment of the applicable renewal fees and taxes as by a date set forth by the DFS following the month during which the appointments will expire.

Appointment of Agent or Other Representative - According to F.S. § 626.451, each appointing entity or person designated by the DFS to administer the appointment process appointing an agent, adjuster, service representative, customer representative, or managing general agent in this state must file the appointment with the DFS and, at the same time, pay the applicable appointment fee and taxes. Every appointment will be subject to the prior issuance of the appropriate agent’s, adjuster’s, service representative’s, customer representative’s, or managing general agent’s license.

By authorizing the effectuation of an appointment for a licensee, the appointing entity is thereby certifying to the DFS that an investigation of the licensee has been made and that in the appointing entity’s opinion and to the best of its knowledge and belief, the licensee is of good moral character and reputation, and is fit to engage in the insurance business. The appointing entity must provide to the DFS any other information the DFS may reasonably require relative to the proposed appointee.

Each appointing entity must advise the DFS in writing within 15 days after it or its general agent, officer, or other official becomes aware that an appointee has pleaded guilty or nolo contendere to or has been found guilty of a felony after being appointed.

Any law enforcement agency or state attorney’s office that is aware that an agent, adjuster, service representative, customer representative, or managing general agent has pleaded guilty or nolo contendere to or has been found guilty of a felony must notify the DFS of such fact.

Each licensee must advise the DFS in writing within 30 days after having been found guilty of or having pleaded guilty or nolo contendere to a felony or a crime punishable by imprisonment of 1 year or more under the laws of the United States, any state of the United States, or any other country, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases.

LICENSE AND APPOINTMENT REQUIRED

An individual, firm, partnership, corporation, association, or other entity shall not act in its own name or under a trade name as an insurance agency, unless it complies with 626.172 with respect to possessing an insurance agency license for each place of business at which it engages in an activity that may be performed only by a licensed insurance agent. However, an insurance agency that is owned and operated by a single licensed agent conducting business in his or her individual name and not employing or otherwise using the services of or appointing other licensees shall be exempt from the agency licensing requirement of this subsection. A branch place of business that is established by a licensed agency is considered a branch agency and is not required to be licensed so long as it transacts business under the same name and federal tax identification number as the licensed agency and has designated with the department a licensed agent in charge of the branch location as required and
the address and telephone number of the branch location have been submitted to the department for inclusion in the licensing record of the licensed agency within 30 days after insurance transactions begin at the location.

If an agency is required to be licensed but fails to file an application for licensure in accordance with this section, the DFS will impose on the agency an administrative penalty in an amount of up to $10,000. Effective October 1, 2015, the DFS must automatically convert the registration of a registered insurance agency to an insurance agency license.

If an agency is eligible for registration but fails to file an application for registration or an application for licensure in accordance with this section, the DFS will impose on the agency an administrative penalty in an amount of up to $5,000. A registered insurance agency must, as a condition to continuing business, obtain an insurance agency license if the DFS finds that any majority owner, partner, manager, director, officer, or other person who manages or controls the agency, any person has:

- Been found guilty or has pleaded guilty or nolo contendere to, a felony in any state other state relating to the business of insurance or to an insurance agency, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of the cases.
- Employed any individual in a managerial capacity or in a capacity dealing with the public who is under an order of revocation or suspension issued by the DFS. An insurance agency may request verification of any person’s license status. If a request is mailed within 5 working days after an employee is hired, and the employee’s license is currently suspended or revoked, the agency will not be required to obtain a license, if the unlicensed person’s employment is immediately terminated.
- With such frequency as to have made the operation of the agency hazardous to the insurance-buying public or other persons:
  - Solicited or handled controlled business.
  - Misappropriated, converted, or unlawfully withheld moneys belonging to insurers, insureds, beneficiaries, or others and received in the conduct of business under the license.
  - Unlawfully rebated, attempted to unlawfully rebate, or unlawfully divided or offered to divide commissions with another.
  - Misrepresented any insurance policy or annuity contract, or used deception with regard to any policy or contract, done either in person or by any form of dissemination of information or advertising.
  - Violated any provision of this code or any other law applicable to the business of insurance in the course of dealing under the license.
  - Violated any lawful order or rule of the DFS.
  - Failed or refused, upon demand, to pay over to any insurer he or she represents or has represented any money coming into his or her hands belonging to the insurer.
  - Violated the provision against twisting.
  - In the conduct of business, engaged in unfair methods of competition or in unfair or deceptive acts or practices.
  - Willfully over insured any property insurance risk.
  - Engaged in fraudulent or dishonest practices in the conduct of business arising out of activities related to insurance or the insurance agency.
  - Demonstrated lack of fitness or trustworthiness to engage in the business of insurance arising out of activities related to insurance or the insurance agency.
- Authorized or knowingly allowed individuals to transact insurance who were not then licensed as required by this code.
- Knowingly employed any person who within the preceding 3 years has had his or her relationship with an agency terminated in accordance with paragraph (d).
- Willfully circumvented the requirements or prohibitions of this code.

Continuation of Appointment of Agent or Other Representative - According to F.S. 626.461, subject to renewal or continuation by the appointing entity, the appointment of the agent, adjuster, service representative, customer representative, or managing general agent will continue in effect until the person’s license is revoked or otherwise terminated, unless written notice of earlier termination of the appointment is filed with the DFS or person designated by the DFS to administer the appointment process by either the appointing entity or the appointee.

Duties of Licensed vs. Unlicensed Personnel - An insurer, a managing general agent, an insurance agency, or an agent, directly or through a representative, may not furnish to an agent any blank forms, applications, stationery, or other supplies to be used in soliciting, negotiating, or effecting contracts of insurance on its behalf unless such blank forms, applications, stationery, or other supplies relate to a class of business for which the agent is licensed and appointed, whether for that insurer or another insurer. An insurer, general agent, insurance agency, or agent who furnishes any of the supplies to an agent or prospective agent not appointed to represent the insurer and who accepts from or writes any insurance business for such agent or agency is subject to civil liability to an insured of such insurer to the same extent and manner as if such agent or prospective agent had been appointed or authorized by the insurer or such agent to act on its or his or her behalf.

Failure to Complete CE Requirements - According to F.S. 626.2815(10), the DFS may immediately terminate or refuse to renew the appointment of an agent or adjuster who has been notified by the DFS that his or her continuing education requirements have not been certified, unless the agent or adjuster has been granted an extension or waiver by the DFS. The DFS may not issue a new appointment of the same or similar type to a licensee who was denied a renewal appointment for failing to complete continuing education as required until the licensee completes his or her continuing education requirement.

ii. Contact information

Contact Information - According to F.S. § 626.541, any licensed agent or adjuster doing business under a firm or corporate name or under any business name other than his or her own individual name must, within 30 days after the initial transaction of insurance under such business name, file with the DFS, on forms adopted and furnished by the DFS, a written statement of the firm, corporate, or business name being so used, the address of any office or offices or places of business making use of such name, and the name and social security number of each officer and director of the corporation and of each individual associated in such firm or corporation as to the insurance transactions thereof or in the use of such business name.

In the event of any change of such name, or of any of the officers and directors, or of any of such addresses, or in the personnel so associated, written notice of such change must be filed with the DFS within 30 days by or on behalf of those licensees terminating any such firm, corporate, or business name or continuing to operate thereunder.

Any licensed insurance agency must, within 30 days after a change, notify the DFS of any change in the information contained in the application filed.

Notice of Change of Address or Name - According to F.S. § 626.551, a licensee must notify the DFS, in writing, within 30 days after a change of name, residence address, principal business street address, mailing address, contact telephone numbers, including a business telephone number, or e-mail address. A licensee who has moved his or her principal place of residence and principal place of business from this state must have his or her license
and all appointments immediately terminated by the DFS. Failure to notify the DFS within the required time will result in a fine not to exceed $250 for the first offense and a fine of at least $500 or suspension or revocation of the license.

iii. Insurance agency licensing

Application for Insurance Agency License - According to F.S. 626.172, the DFS may issue a license as an insurance agency to any person only after such person files a written application with the DFS and qualifies for such license.

An application for an insurance agency license must be signed by an individual required to be listed in the application under paragraph (a). An insurance agency may permit a third party to complete, submit, and sign an application on the insurance agency’s behalf; however, the insurance agency is responsible for ensuring that the information on the application is true and correct and is accountable for any misstatements or misrepresentations.

- The application for an insurance agency license must include:  
  The name of each owner, partner, officer, director, president, senior vice president, secretary, treasurer, and limited liability company member who directs or participates in the management or control of the insurance agency, whether through ownership of voting securities, by contract, by ownership of any agency bank account, or otherwise.
- The residence address of each person required to be listed in the application.
- The name, principal business street address, and valid email address of the insurance agency and the name, address and email address of the agency’s registered agent or person or company authorized to accept service on behalf of the agency.
- The physical address of each branch agency including its name, email address, and telephone number, and the date that the branch location began transacting insurance.
- The name of the agent in full-time charge of the agency office, including branch locations.
- The fingerprints of each of the following:
  - A sole proprietor;
  - Each individual required to be listed in the application under paragraph (a);
  - Each individual who directs or participates in the management or control of an incorporated agency whose shares are not traded on a securities exchange; and
- Fingerprints must be taken by a law enforcement agency or other entity approved by the DFS and must be accompanied by the fingerprint processing fee. Such additional information as the DFS requires by rule to ascertain the trustworthiness and competence of persons required to be listed on the application and to ascertain that such persons meet the requirements of this code. However, the DFS may not require that credit or character reports be submitted for persons required to be listed on the application. The DFS must accept the uniform application for nonresident agency licensure and may adopt revised versions. The DFS must issue a license to each agency upon approval of the application, and each agency location must display the license prominently in a manner that makes it clearly visible to any customer or potential customer who enters the agency location.
- Continuation, Expiration of License; Insurance Agencies - According to F.S. 626.382, the license of an insurance agency shall continue in force until canceled, suspended, or revoked, or until it is otherwise terminated or expires by operation of law.
- Insurance Agency Names; Disapproval - According to F.S. 626.602, the DFS may disapprove the use of any true or fictitious name, other than the bona fide natural name of an individual, by any insurance agency on any of the following grounds: The name interferes with or is too similar to a name already filed and in
use by another agency or insurer. The use of the name may mislead the public in any respect. The name states or implies that the agency is an insurer, motor club, hospital service plan, state or federal agency, charitable organization, or entity that primarily provides advice and counsel rather than sells or solicits insurance, or is entitled to engage in insurance activities not permitted under licenses held or applied for. This provision does not prohibit the use of the word state or states in the name of the agency. The use of the word state or states in the name of an agency does not in and of itself imply that the agency is a state agency.

Third parties may sign agency applications for licensure. The insurance agency is responsible for ensuring that the information on the application is true and correct and is accountable for any misstatements or misrepresentations.

If an insurance agency is owned and operated by a single licensed agent (sole proprietor) conducting business in his/her individual name only, the agency is exempt from requiring the office location to be licensed as an agency. The agent may have administrative staff that are not licensed. If the agent is joined by another licensee at the location, it must be licensed as an insurance agency.

Insurance agencies are no longer able to obtain a registration in lieu of a license.

Branch Locations

Branch locations of insurance agencies **do not need** to be licensed as insurance agencies as long as the branch locations:

- Transact insurance under the same name and federal identification number as the main or parent location
- Notify the Department of the address and phone number of the location via the parent location’s MyProfile account
- Place an agent in charge that has been properly designated to the location via the agency's MyProfile account.

Branch agency locations need not submit fingerprints for owners and officers when adding new locations as long as the ones listed for the parent agency location remain as the current ones. If there are new owners and officers of an agency, then the agency must notify the Department and submit those fingerprints.

Each place of business must be in the active full-time charge of an agent who is licensed and appointed to transact the lines of business being handled at that location via the agency’s MyProfile account. The licensed agent in charge of an insurance agency may also be the agent in charge of additional branch locations as long as no insurance is transacted at any of the locations when there is not a licensed and appointed agent physically present at that location.

Continuation, Expiration of License; Insurance Agencies

Effective January 1, 2015, agency licenses are perpetual as long as there is a designated agent in charge.

Each place of business must be in the active full-time charge of an agent who is licensed and appointed to transact the lines of business being handled at that location. If an agent in charge is **not** designated for that location, an insurance agency may not conduct business. Changes to the agent in charge must be made by the insurance agency within 30 days of the change. If the agency does not designate a new agent in charge with the DFS **within 90 days after the agent in charge on record has left the agency or no longer is qualified to act as an agent in charge**, the agency license will automatically expire.
Responsibilities of the Agent in Charge

The agent in charge is responsible for the supervision of all individuals within an insurance agency location. The agent in charge is accountable for misconduct or violations of the insurance code committed by anyone at the agency, however, this does not mean the agent in charge will automatically be held criminally liable for an act unless he/she knew or should have known of the act and the facts surrounding the criminal activity.

iv. Transfer, surrender and termination of licensing

License or Appointment Transferability - According to F.S. § 626.441, a license or appointment issued is valid only to the person named and is not transferable to another person. No licensee or appointee will allow any other person to transact insurance by utilizing the license or appointment issued to such licensee or appointee.

Transfer of License from Another State - According to F.S. 626.292, an individual licensed in good standing in another state may apply to the DFS to have the license transferred to this state to obtain a resident agent or all-lines adjuster license for the same lines of authority covered by the license in the other state.

To qualify for a license transfer, an individual applicant must meet the following requirements:

- The individual must become a resident of this state.
- The individual must have been licensed in another state for a minimum of 1 year immediately preceding the date the individual became a resident of this state.
- The individual must submit a completed application for this state which is received by the DFS within 90 days after the date the individual became a resident of this state, along with payment of the applicable fees and submission of the following documents:
  - A certification issued by the appropriate official of the applicant’s home state identifying the type of license and lines of authority under the license and stating that, at the time the license from the home state was canceled, the applicant was in good standing.
  - A set of the applicant’s fingerprints.
  - The individual must satisfy prelicensing education requirements in this state, unless the completion of prelicensing education requirements was a prerequisite for licensure in the other state and the prelicensing education requirements in the other state are substantially equivalent to the prelicensing requirements of this state as determined by the DFS. This paragraph does not apply to all-lines adjusters. The individual must satisfy the examination requirement under s. 626.221, unless exempted. An applicant satisfying the requirements for a license transfer under subsection will be approved for licensure in this state unless the DFS finds that grounds exist under for refusal, suspension, or revocation of a license.

Denial, suspension, or revocation of a license to practice or conduct any regulated profession, business, or vocation relating to the business of insurance by this state, any other state, any nation, any possession or district of the United States, any court, or any lawful agency thereof. However, the existence of grounds for administrative action against a licensed agency does not constitute grounds for action against any other licensed agency, including an agency that owns, is under common ownership with, or is owned by, in whole or in part, the agency for which grounds for administrative action exist.

Duration of Suspension or Revocation - According to F.S. § 626.641, the DFS may specify the period during which the suspension is to be in effect; but such period must not exceed 2 years. The license, appointment, or eligibility will remain suspended during the period so specified, subject, however, to any rescission or modification of the
order by the DFS, or modification or reversal thereof by the court, prior to expiration of the suspension period. A license, appointment, or eligibility that has been suspended will not be reinstated except upon the filing and approval of an application for reinstatement and, in the case of a second suspension, completion of continuing education courses prescribed and approved by the DFS; but the DFS will not approve an application for reinstatement if it finds that the circumstance or circumstances for which the license, appointment, or eligibility was suspended still exist or are likely to recur. In addition, an application for reinstatement is subject to denial and subject to a waiting period prior to approval on the same grounds that apply to applications for licensure.

No person or appointee under any license or appointment revoked by the DFS, nor any person whose eligibility to hold same has been revoked by the DFS, will have the right to apply for another license or appointment under this code within 2 years from the effective date of such revocation or, if judicial review of such revocation is sought, within 2 years from the date of final court order or decree affirming the revocation. An applicant for another license or appointment according to this subsection must apply and qualify for licensure in the same manner as a first-time applicant, and the application may be denied on the same grounds that apply to first-time applicants for licensure. In addition, the DFS will not grant a new license or appointment or reinstate eligibility to hold such license or appointment if it finds that the circumstance or circumstances for which the eligibility was revoked or for which the previous license or appointment was revoked still exist or are likely to recur; if an individual’s license as agent or customer representative or eligibility to hold same has been revoked upon the ground, the DFS will refuse to grant or issue any new license or appointment so applied for.

If any of an individual’s licenses as an agent or customer representative or the eligibility to hold such license or licenses has been revoked at two separate times, the DFS may not thereafter grant or issue any license under this code to such individual. If a license as an agent or customer representative or the eligibility to hold such a license has been revoked resulting from the solicitation or sale of an insurance product to a person 65 years of age or older, the DFS may not thereafter grant or issue any license under this code to such individual.

During the period of suspension or revocation of a license or appointment, and until the license is reinstated or, if revoked, a new license issued, the former licensee or appointee may not engage in or attempt or profess to engage in any transaction or business for which a license or appointment is required under this code or directly or indirectly own, control, or be employed in any manner by an agent, agency, adjuster, or adjusting firm.

Surrender of License - According to F.S. § 626.661, though issued to a licensee, all licenses issued under this chapter are at all times the property of the State of Florida; and, upon notice of any suspension, revocation, refusal to renew, failure to renew, expiration, or other termination of the license, such license will no longer be in force and effect.

Expiration of License and Appointment

Upon the expiration of any person’s appointment, as provided in F.S.626.381, the person will be without any authority conferred by the appointment and will not engage in or attempt to engage in any activity requiring an appointment. When a licensee’s last appointment for a particular class of insurance has been terminated or not renewed, the DFS must notify the licensee that his or her eligibility for appointment as such an appointee will expire unless he or she is appointed prior to expiration of the 48-month period.

An individual who fails to maintain an appointment with an appointing entity writing the class of business listed on his or her license during any 48-month period will not be granted an appointment for that class of insurance until he or she qualifies as a first-time applicant.
Prohibition Against Unlicensed Transactions of Life Insurance - According to F.S. 626.7845, an individual may not solicit or sell variable life insurance, variable annuity contracts, or any other indeterminate value or variable contract unless the individual has successfully completed a licensure examination relating to variable annuity contracts authorized and approved by the DFS. No individual can, unless licensed as a life agent: Solicit insurance or annuities or procure applications; In this state, engage or hold himself or herself out as engaging in the business of analyzing or abstracting insurance policies or of counseling or advising or giving opinions to persons relative to insurance or insurance contracts other than:

- As a consulting actuary advising an insurer; or
- As to the counseling and advising of labor unions, associations, trustees, employers, or other business entities, the subsidiaries and affiliates of each, relative to their interests and those of their members or employees under insurance benefit plans; or In this state, from this state, or with a resident of this state, offer or attempt to negotiate on behalf of another person, a viatical settlement contract.

v. Grounds for compulsory/discretionary refusal, suspension, or revocation of insurance license/agency license/appointment

Grounds for Compulsory Refusal, Suspension, or Revocation of License - According to F.S. § 626.611, the DFS will deny an application, suspend, revoke, or refuse to renew or continue the license or appointment of any applicant, agent, title agency, adjuster, customer representative, service representative, or managing general agent, and it will suspend or revoke the eligibility to hold a license or appointment of any person, if it finds any one or more of the following applicable grounds exist:

- Lack of one or more of the qualifications for the license or appointment
- Material misstatement, misrepresentation, or fraud in obtaining the license or appointment or in attempting to obtain the license or appointment.
- Failure to pass to the satisfaction of the DFS any examination required under this code.
- Fraudulent or dishonest practices in the conduct of business under the license or appointment.
- Misappropriation, conversion, or unlawful withholding of moneys belonging to insurers or insureds or beneficiaries or to others and received in conduct of business under the license or appointment.
- Unlawfully rebating, attempting to unlawfully rebate, or unlawfully dividing or offering to divide his or her commission with another.
- Having been found guilty of or having pleaded guilty or nolo contendere to a felony or a crime punishable by imprisonment of 1 year or more under the law of the United States of America or of any state thereof or under the law of any other country which involves moral turpitude, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases.

The DFS will deny, suspend, revoke, or refuse to continue the license of any insurance agency if it finds, as to any insurance agency or as to any majority owner, partner, manager, director, officer, or other person who manages or controls such agency, that any of the following applicable grounds exist:

- Lack by the agency of one or more of the qualifications for the license as specified in this code.
- Material misstatement, misrepresentation, or fraud in obtaining the license or in attempting to obtain the license.
- Denial, suspension, or revocation of a license to practice or conduct any regulated profession, business, or vocation relating to the business of insurance by this state, any other state, any nation, any possession or district of the United States, any court, or any lawful agency thereof. However, the existence of grounds
for administrative action against a licensed agency does not constitute grounds for action against any other licensed agency, including an agency that owns, is under common ownership with, or is owned by, in whole or in part, the agency for which grounds for administrative action exist.

Revocation of License - According to F.S. 626.441, if any licensee is convicted by a court of a violation of the Florida Insurance Code or a felony, the licenses and appointments will be immediately revoked by the DFS. The licensee may subsequently request a hearing and the DFS will expedite any such requested hearing. The sole issue at such hearing will be whether the revocation should be rescinded because such person was not in fact convicted of a violation of this code or a felony.

The papers, documents, reports, or evidence of the DFS relative to a hearing for revocation or suspension of a license or appointment. According to the provisions of this Chapter and Chapter 120 are confidential and exempt from the provisions of F.S. 119.07(1) until after the same have been published at the hearing. However, such papers, documents, reports, or items of evidence are subject to discovery in a hearing for revocation or suspension of a license or appointment.

Effect of Suspension or Revocation upon Associated Agencies - According to F.S. § 626.6515, upon suspension or revocation of the license of an insurance agency, the DFS may at the same time revoke, suspend, or refuse to continue the license of any other insurance agency under the management, ownership, control, or directorship of any person or persons who participated in activities which resulted in the suspension, revocation, or refusal to continue the initial license if acts occurred at that specific agency location which are grounds for refusal, suspension, or revocation of a license under this code. The DFS will not, during the period of revocation or suspension, grant any new license for the establishment of any additional agency not in operation at the time of suspension, revocation, or refusal to any agency under or proposed to be under substantially the same management, ownership, control, or directorship of individuals who directed or participated in activities which resulted in suspension, revocation, or refusal of an agency license.

Duration of Suspension or Revocation - According to F.S 626.641, the DFS must, in its order suspending a license or appointment or in its order suspending the eligibility of a person to hold or apply for such license or appointment, specify the period during which the suspension is to be in effect; but such period must not exceed 2 years. The license, appointment, or eligibility will remain suspended during the period so specified, subject, however, to any rescission or modification of the order by the DFS, or modification or reversal thereof by the court, prior to expiration of the suspension period. A license, appointment, or eligibility that has been suspended must not be reinstated except upon the filing and approval of an application for reinstatement and, in the case of a second suspension, completion of continuing education courses prescribed and approved by the DFS; but the DFS will not approve an application for reinstatement if it finds that the circumstance or circumstances for which the license, appointment, or eligibility was suspended still exist or are likely to recur. In addition, an application for reinstatement is subject to denial and subject to a waiting period prior to approval on the same grounds that apply to applications for licensure.

FAILURE TO COMPLETE CE REQUIREMENTS

Case: An investigation of a life & health agent alleged that while serving in the capacity of an insurance instructor he provided continuing education credits without the person actually taking the class. The agent/instructor would simply request a check payable to him and he would then send a Certificate of Completion.
Disposition: License revoked. He was arrested and convicted of multiple felony counts making him permanently ineligible for future licensure.

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vi. Duties of licensed vs. unlicensed personnel

Duties of Licensed vs. Unlicensed Personnel

An insurer, a managing general agent, an insurance agency, or an agent, directly or through a representative, may not furnish to an agent any blank forms, applications, stationery, or other supplies to be used in soliciting, negotiating, or effecting contracts of insurance on its behalf unless such blank forms, applications, stationery, or other supplies relate to a class of business for which the agent is licensed and appointed, whether for that insurer or another insurer.

An insurer, general agent, insurance agency, or agent who furnishes any of the supplies to an agent or prospective agent not appointed to represent the insurer and who accepts from or writes any insurance business for such agent or agency is subject to civil liability to an insured of such insurer to the same extent and manner as if such agent or prospective agent had been appointed or authorized by the insurer or such agent to act on its or his or her behalf.

Agency Personnel Powers, Duties, and Limitations - According to F.S. § 626.0428, an individual employed by an agent or agency on salary who devotes full time to clerical work, with incidental taking of insurance applications or quoting or receiving premiums on incoming inquiries in the office of the agent or agency, is not deemed to be an agent or customer representative if his or her compensation does not include in whole or in part any commissions on such business and is not related to the production of applications, insurance, or premiums.

An employee of an agent or agency may not bind insurance coverage unless licensed and appointed as an agent or customer representative.

An employee of an agent or agency may not initiate contact with any person for the purpose of soliciting insurance unless licensed and appointed as an agent or customer representative. As to title insurance, an employee of an agent or agency may not initiate contact with any individual proposed insured for the purpose of soliciting title insurance unless licensed as a title insurance agent or exempt from such licensure.

Prohibition against Unlicensed Transactions of Life Insurance - According to F.S. § 626.7845, an individual may not solicit or sell variable life insurance, variable annuity contracts, or any other indeterminate value or variable contract unless the individual has successfully completed a licensure examination relating to variable annuity contracts authorized and approved by the DFS.

- No individual can, unless licensed as a life agent:
  - Solicit insurance or annuities or procure applications;
  - In this state, engage or hold himself or herself out as engaging in the business of analyzing or abstracting insurance policies or of counseling or advising or giving opinions to persons relative to insurance or insurance contracts other than:
    - As a consulting actuary advising an insurer; or
    - As to the counseling and advising of labor unions, associations, trustees, employers, or other business entities, the subsidiaries and affiliates of each, relative to their interests and those of their members or employees under insurance benefit plans; or
• In this state, from this state, or with a resident of this state, offer or attempt to negotiate on behalf of another person, a viatical settlement contract.

C. Other requirements

Agents must also be aware of other important rules and regulations that apply to their day-to-day insurance practices. The Florida Insurance Codes defines a number of guidelines that agents must follow when advertising products and services and with regard to keeping records.

i. Advertising

Ethical Use of Sales Tools

The term "sales tools" includes almost everything that an agent uses to create interest in purchasing or keeping the products marketed by the agent. This includes everything from the stationery and business cards the agent uses, to advertisements he or she places, direct mail sent, personal brochures distributed, magazine and newsletter articles written, to the seminar scripts and product illustrations used in the sales presentation.

Various regulatory bodies may assign these sales tools different names - advertisements, educational materials, invitations to inquire, invitations to purchase - this course will refer these collectively as "sales tools". Every communication designed to influence a decision to purchase or retain a product that is seen or heard by the client or prospective client should be considered a sales tool. Although this is a broad interpretation of what a sales tools is, it may be no broader than the courts would interpret the term. The overriding sales tools ethical issue is that they convey information fairly and honestly without misleading the client.

The important points addressed in this lesson are:

• The term "sales tools" includes almost everything used by the financial services agent to create interest in purchasing or keeping financial products.
• Information contained on the agent's letterhead and business cards must be sufficient to identify the agent and his or her company without misleading the prospect.
• Advertising and direct mail present special ethics challenges because their necessary brevity makes it impossible for them to provide full disclosure.
• Personal brochures give the agent an opportunity to showcase his or her experience, education, skills and credentials but must not mislead the prospect.
• Magazine articles published under the agent's name are generally designed to position him or her as an expert in the subject of the article; an ethical problem may arise if that implication is incorrect.

Letterhead and Business Cards

How agents identify themselves on a business card or letterhead is important since these are, typically, the client's first introduction to the agent. The key ethical consideration when an agent designs his or her letterhead and business cards is to include sufficient information to adequately identify him or her and the company being represented without being misleading. Agents generally have fairly wide latitude in designing stationery and business cards with respect to both the design and language that is used, although some companies may have more stringent requirements than others.
Consider, for example, the letterhead for a Certified Financial Planner (CFP®) designee. While the principal of the agency may be a Certified Financial Planner CFP®, perhaps not all employees/associates of the firm hold that designation. So while "Jared Jones, CFP® and Associates" would be accurate, "Jared Jones and Associates CFP®" could be misleading as it gives the impression that Jared and all of the associates hold a CFP designation. Similar problems can arise with other titles and professional designations. In addition, each professional organization will have its own rules for proper usage of its designation. It is important that the agent comply with those rules and well as making sure that the designation's use is not misleading. And obviously, the use of the designations CPCU, CLU, CFP, ChFC or CPA would be improper and deceptive unless the agent had earned them.

Widely recognized professional designations can add credibility to an agent's business card or letterhead. But what of most general terms and titles, such as "financial planner" or "investment advisor". Some jurisdictions have guidelines on what terminology can be used, and under what circumstances those terms can be used. (For example, "registered investment adviser" is reserved for those who have passed a licensing examination and are registered with the SEC.) Other times the agent is left to his or her own good judgment. The key question an agent should ask in these situations is: "Does the title mislead?" Generally speaking it is best to stick with traditional titles such as insurance agent or stockbroker to describe oneself.

When an agent holds a title from a firm, such as registered representative, the agent should include the name and address of the broker/dealer whom the agent represents. To omit the company affiliation would be to mislead prospective clients as to the nature of the title. For those agents who use the products of multiple companies, it is important that if products are listed the company with whom each product is placed and its principal home office address should also be supplied.

It is important that an agent's business card and letterhead permit the client or prospect to properly identify him or her as a property and casualty agent, a life insurance agent, a stockbroker, a registered representative, a registered investment adviser, etc. In addition, when a client receives the piece he or she should be able to determine what the agent sells.

Advertising and Direct Mail

As with all customer communications, the primary ethical consideration for advertising and direct mail is that it not be misleading to the reader or viewer. This requires the agent to present the material in a way that is not only honest, but also understandable. To that end, the agent should consider the level of understanding of the target audience. Different media reach different audiences. The mass media - general newspapers, radio, television - reach a general audience. Subscribers of trade publications typically have a deeper grasp of relevant subject matter. An agent's deliberate use of complex, albeit truthful, information in the mass media could be considered deceptive because of the target audience's lack of sophistication - and therefore, unethical.

Direct mail is normally used to generate interest in the recipient in order to schedule a sales appointment. Obviously, it is important to generate the maximum interest possible in the financial products and services highlighted in the direct mail being used. The principal ethical difficulty with respect to direct mail and advertising is its relative brevity. It is often impossible to make a full disclosure in a piece of direct mail or in an advertisement. There just isn't sufficient time or space. Since the advertising or direct mail used must be brief as well as capable of generating prospective client interest it is particularly important that care be taken to ensure that the agent not misrepresent either the product or himself.

Since reader interest must be caught quickly, there may be a tendency to puffery - to present the product in an exaggerated manner by ascribing to it qualities it does not have. For example, the writer may describe the product as new and unique or revolutionary. In many cases involving products other than insurance or investment products, these words are just puffery. In the insurance and investment business, however, the use of language
that describes the offering as "new" or "best" - unless it clearly is and can be verified - or any other exaggeration must be scrupulously avoided. Both legally and ethically, it must not be done.

The limited space normally available in direct mail letters makes including qualifying information that might be necessary to a complete understanding of the offering difficult. As a result, information concerning exclusions, conditions, and other limitations is not included.

One of the important advantages enjoyed by life insurance products is its favorable tax treatment. An agent may want to emphasize that benefit in direct mail letters. Language such as "tax-free," "tax-favored," "tax-advantaged," or other words that point to the tax benefits of life insurance should not be used without additional qualifying language that invites the reader to check with his tax adviser for applicability in his specific situation.

Because of the inability to provide complete disclosure, it is a good idea to avoid discussing specific products or product features in advertising or direct mail. Unless the product or feature can be explained completely, the direct mail or advertising that discusses them runs a good chance of misleading the reader. Because full disclosure is generally impractical in these communications, specific product discussion should usually be avoided. Furthermore, the use of superlatives-words like best, lowest cost, lowest risk, safest, and other similar words-unless they are true and can be verified could mislead the reader and should be avoided.

Personal Brochures

How does an insurance agent "stand out from the crowd"? In a perfectly competitive market - that is, one with many buyers and sellers competing over interchangeable products - one wouldn't have to ask that question. Price alone would determine success. But we do ask that question, because insurance agents, like many other providers of services, operate in a marketplace that can be characterized as "monopolistically competitive". It is competitive because there are many sellers in the market. It is monopolistic in that each seller is unique - offering clients their individual talents and skills and a slightly different set of products than any other agent. Agents and others in the financial services industry are often interested in differentiating their practice from that of other agents or agents. A personal brochure can be used to highlight their differences.

The guiding ethical principle when developing a personal brochure is that - at the very least - the brochure must provide information sufficient to allow the reader to understand the:

- identity of the agent
- business or businesses the agent engages in
- products sold to accomplish the objectives stated in the brochure
- companies represented, their addresses and telephone numbers, and
- agent's address and telephone number.

The typical brochure highlights personal achievements, education, professional designations, membership in civic and professional associations as well as the products and services being offered. As in so many other communications, the ethical requirement is to avoid anything that would mislead the brochure's reader. Areas in a personal brochure that may be abused include:

- claiming to have a professional designation, expertise or education not really possessed
- misstating personal or professional accomplishments
- failure to include important information, such as that the services offered or results claimed are provided through the use of stocks, bonds, life insurance, mutual funds, annuities, etc.
Personal brochures can provide a big lift to an agent’s marketing efforts. It is important for ethical and legal reasons, however, to follow these guidelines when creating a personal brochure.

Articles

One common method agents may use to position themselves in a particular market is by writing articles for magazines or newsletter that serve those markets. Besides the exposure such articles bring, they also provide the agent with an aura of authority. As a result, agents sometimes publish articles in order to develop a reputation as an authority in a particular field or as a specialist in the needs of a specific target market. Of course, the ultimate purpose behind such an article is to generate business. In light of that intent, the article should be considered an advertisement and judged ethically by the criteria that apply to advertising. As with all other forms of advertising in the insurance and investment business, the information provided must be factually correct, understandable to the expected audience and not misleading.

As insurers and broker-dealers have begun to appreciate the desirability of target marketing and the importance of positioning agents within markets, they have come to realize the importance of providing articles for publication in magazines serving those markets. Many companies maintain a large number of such articles on various financial and insurance subjects that are suitable for many markets. Often, the agent needs only to add his or her name to the article and send it to the publisher. Since these articles are usually written by home office specialists and reviewed by compliance attorneys, they can be expected to be factually correct and not misleading.

The ethical issue for the agent in appending his or her name to an article written by a specialist is twofold: the purported author did not write the piece, and the agent may not possess the expertise and specialized knowledge implied by the published article. The first ethical concern may be resolved through the use of language clearly stating the article is made available by the agent rather than having been written by him or her. The second ethical concern—that the implied expertise may not be possessed—can be overcome by ensuring that the agent not have articles published unless he or she actually possesses the expertise implied.

To protect consumers, Florida regulates the content of life and health insurance advertisements to ensure that the public receives clear and unambiguous information about the benefits, limitations, and exclusions of these insurance contracts. The Florida Insurance Code sets forth specific guidelines that insurers must follow to make sure that advertisements are accurate and not deceptive or misleading.

So what is considered advertising? The definition is fairly broad, and includes a wide used to solicit insurance, including the following, newspapers, magazines, and other publications as well as pamphlets, letters, and posters. Billboards, sales presentations, and television and radio advertisements are regulated as well. While the rules for using social media, such as Twitter, Facebook and LinkedIn, to promote insurance products are not as clearly defined, it would be in the best interest of agents and insurers to clearly monitor any statements made on such “social media” to avoid running afoul of the insurance rules prohibiting improper inducements, misleading representations, and deceptive advertising.

Approval by Insurer

Insurance companies are responsible for the content of all advertisements that directly or indirectly benefit them. An agent may use only such advertising pertaining to the business underwritten by an insurer as has been approved in writing by such insurer in advance of its use. Some types of advertisements—including those for long-term care and Medicare supplement insurance—must be filed with the Office of Insurance Regulation (OIR) before they can be used.

Identification of Insurers, Agents, and Insurance Contracts
Advertising materials and other communications developed by insurers, or other risk bearing entities authorized under this code and approved by the OIR to do business in this state, regarding insurance products must clearly indicate that the communication relates to insurance products. When soliciting or selling insurance products, agents must clearly indicate to prospective insureds that they are acting as insurance agents with regard to insurance products and identified insurers, or other risk bearing entities authorized under this code and approved by the office to do business in this state.

In addition, advertisements must clearly identify the insurer and that the policy advertised is a “health insurance policy,” “life insurance policy,” or “annuity contract.” An advertisement must also refer to the product’s generic names such as a “group term life,” “flexible premium life,” or “immediate annuity.” If an advertisement includes any statistics, it must disclose the source of the statistics.

The Florida Insurance Code also prohibits insurers from using marketing materials that give the impression that an insurer or its products are recommended or endorsed by a governmental entity, society, association, or other organization unless it is true.

Advertisements must disclose the policy provisions relating to renewability, cancelability and termination.

Advertisements cannot imply that claim settlements will be liberal or generous beyond the terms of the policy. They also cannot contain statements about an insurer’s assets, financial standing, or position in the insurance industry that are untrue or misleading.

Sometimes, advertisements may include testimonials from a spokesperson about different insurance products. While testimonials may be used, they must be genuine and represent the author’s current opinion. They also must be reproduced accurately and completely enough to avoid misleading prospective customers about the nature or scope of the endorsement. If a person is paid for an endorsement, this fact must be disclosed in the advertisement as well.

Methods of marketing insurance.

An advertisement cannot make unfair or incomplete comparisons of policies or benefits offered by other insurers. It cannot disparage competitors, their products, services, or business methods, and cannot disparage other methods of marketing insurance. Advertisements also cannot use certain words or phrases that could be misleading, such as “no red tape” or “here is all you have to do to receive benefits.” Misleading awards, such as “safe driver awards,” cannot be used in advertisements for health insurance.

Advertisement for group policies may not state or imply that prospective policyholders become group or quasi-group members and enjoy special rates or underwriting privileges, unless that is true. And finally, an advertisement may not state or imply that a particular policy is an introductory, initial or special offer and that the applicant will receive advantages by accepting the offer, unless that is true.

Unfair Methods of Competition and Unfair or Deceptive Acts or Practices

Advertising Gifts Permitted - Some types of advertisements including those for long-term care and Medicare supplement insurance must be filed with the Office of Insurance Regulation (OIR) before they can be used. Identification of insurers, Agents, and Insurance Contracts Advertising materials and other communications developed by insurers, or other risk bearing entities authorized under this code and approved by the OIR to do business in this state, regarding insurance products must clearly indicate that the communication relates to insurance products.

Insurers and agents generally cannot pay or offer to pay anything of value (up to $100 in aggregate) for someone to buy insurance, including a rebate of the premium, dividends, or stocks and securities. Agents and companies
may, for advertising purposes, provide applicants with gifts valued up to $100 in aggregate. Department rules define gifts as "articles of merchandise". The Department does not recognize gift certificates, memberships or other services as "merchandise". Consequently, agents who give away auto club memberships, gift certificates or cash violate the Insurance Code.

According to F.S. 626.9541(m), advertising gifts are permitted as long as the insurer or its agent makes a gift of merchandise having a value of less than $100 in aggregate. Approval by Insurer Insurance companies are responsible for the content of all advertisements that directly or indirectly benefit them. An agent may use only such advertising pertaining to the business underwritten by an insurer as has been approved in writing by such insurer in advance of its use.

When soliciting or selling insurance products, agents must clearly indicate to prospective insureds that they are acting as insurance agents with regard to insurance products and identified insurers, or other risk bearing entities authorized under this code and approved by the office to do business in this state. In addition, advertisements must clearly identify the insurer and that the policy advertised is a health insurance policy, life insurance policy, or annuity contract.

An advertisement must also refer to the product’s generic names such as a group term life, flexible premium life, or immediate annuity. If an advertisement includes any statistics, it must disclose the source of the statistics. The Florida Insurance Code also prohibits insurers from using marketing materials that give the impression that an insurer or its products are recommended or endorsed by a governmental entity, society, association, or other organization unless it is true.

Advertisements must disclose the policy provisions relating to renewability, cancelability and termination. Advertisements cannot imply that claim settlements will be liberal or generous beyond the terms of the policy. They also cannot contain statements about an insurer’s assets, financial standing, or position in the insurance industry that are untrue or misleading.

Sometimes, advertisements may include testimonials from a spokesperson about different insurance products. While testimonials may be used, they must be genuine and represent the author’s current opinion. They also must be reproduced accurately and completely enough to avoid misleading prospective customers about the nature or scope of the endorsement. If a person is paid for an endorsement, this fact must be disclosed in the advertisement as well.

Advertisements also cannot use certain words or phrases that could be misleading, such as no red tape or here is all you have to do to receive benefits. Misleading awards, such as safe driver awards, cannot be used in advertisements for health insurance. An advertisement cannot make unfair or incomplete comparisons of policies or benefits offered by other insurers. It cannot disparage competitors, their products, services, or business methods, and cannot disparage other methods of marketing insurance. Advertisements also cannot use certain words or phrases that could be misleading, such as no red tape or here is all you have to do to receive benefits.

Misleading awards, such as safe driver awards, cannot be used in advertisements for health insurance.

Advertisements for group policies may not state or imply that prospective policyholders become group or quasi-group members and enjoy special rates or underwriting privileges, unless that is true. And finally, an advertisement may not state or imply that a particular policy is an introductory, initial or special offer and that the applicant will receive advantages by accepting the offer, unless that is true.
ii. Recordkeeping

Recordkeeping - According to F.S. 626.561(2), agents shall keep and make available to the department or office books, accounts and records as will enable the department or office to determine whether such agent is complying with the provisions of this code. Every agent shall preserve books, accounts and records pertaining to premium payments for at least three years after payment. The F.S. law allows agent to maintain premium payment records by electronic or photographic means, as long as they are readily accessible in the agent’s office. The three (3) year requirement does not apply to insurance binders when no policy is ultimately issued and no premium is collected.

According to F.S. 626.4554(6)(a) and (b) somewhat longer recordkeeping requirements apply when life insurance and annuities are sold to consumers. In this case, insurers, insurance agencies, and agents must keep records of all of the information collected from the senior consumer that was used to make a product recommendation for five (5) years. This would include documents such as applications, questionnaires, illustrations, account review documents, and any correspondence between the insurer or agent and the client. Records can be kept in almost any form—paper, photographic, microprocess, magnetic, mechanical, or electrical.

According to F.S. § 626.748 – agents must keep records of policies transacted. These records include daily reports, applications, change endorsements, or documents signed or initialed by the insured concerning the policies. The records must be available to policyholders and the Department upon request. The records must be maintained in the agent’s office or be readily by electronic or photographic means. Since the law does not provide a minimum limit as to how long the policy records must be maintained, it is recommended that they are maintained as long as the agent continues to transact insurance.

Advertising Files - Insurers must keep a file in their home office that contains every advertisement used to market their individual and group insurance policies, along with information explaining how and to what extent the ads were distributed. Insurers must maintain files of advertisements for at least four (4) years or until their next regular examination, whichever period is longer. The OIR can examine an insurer’s advertising file at any time.

D. Department communication

Department Communication The DFS has taken a number of positive steps to make the licensing process faster, easier, and more secure for agents and insurance agencies. On line communications is now the predominant form of communication within the DFS through the Office of Communications.

The Office of Communications has the following duties and responsibilities:

- Write, edit and disseminate DFS communications and press releases
- Compose speeches and presentations
- Create various materials for employees, consumers and customers
- Coordinate community outreach programs
- Monitor the DFS social media outlets

License applications and appointments must now be submitted online, continuing education requirements are reported electronically, and contact information must be updated through an agent’s MyProfile account. Agents doing business in Florida must therefore be aware of the different tools that have been made available to them from within the DFS to communicate to agents and insurers and with the Florida consumer.
Insurance Insights

The DFS’s Division of Insurance Agent and Agency Services produce an online newsletter Insurance Insights, which provides information for agents, adjusters, and agencies about the latest trends and news in the insurance industry. It includes information about the DFS’ current legislature agenda, new initiatives the DFS is launching, changes in the Florida Insurance Code and rules, and continuing education updates. In addition, it also includes the following sections:

- **Compliance Corner** assists agents in keeping their insurance business in compliance. This section highlights various areas in which the DFS has noted a pattern of noncompliance among licensees. It features different rules that agents should be aware of to ensure they are conducting business in compliance with Florida laws. For example, in the March 2014 issue it cleared up some confusion caused by an article in the February 2014 issue with regards to Retention for Agent, Adjuster, and Agency Records. Compliance corner also highlights the types of disciplinary action that may be taken for violating these laws.

- **Case Notes** summarizes the facts of various cases where licensees and other have violated the Florida Insurance code. It highlights the administrative action the DFS has taken against these agents, as well as whether the DFS referred any matters to the Division of Insurance Fraud for criminal investigation.

- **Enforcement Actions** lists the names of the individuals and businesses against whom disciplinary action has been taken, including license suspension, revocation, probations, and fines.

Agents can view current and archive Insurance Insight newsletters at:
http://www.myfloridacfo.com/Division/Agents/Newsletter/News.htm

The DFS’s Division of Insurance Agent and Agency Services issues an online newsletter Insurance Insights, which provides information for agents, adjusters, and agencies about the latest trends and news in the insurance industry. It includes information about the DFS current legislature agenda, new initiatives the DFS is launching, changes in the Florida Insurance Code and rules, and continuing education updates. In addition, Insight also includes a section entitled, Compliance Corner which has been created to assist agents in keeping their insurance business in compliance. This section highlights various areas in which the DFS has noted a pattern of noncompliance among licensees. It features different rules that agents should be aware of to ensure that they are conducting business in compliance with Florida laws. For example, in the March 2014 issue it cleared up some confusion caused by an article in the February 2014 issue with regards to Retention for Agent, Adjuster, and Agency Records. Compliance corner also highlights the types of disciplinary action that may be taken for violating these laws.

Insights also includes a Case Notes section, which summarizes the facts of various cases where licensees and other have violated the Florida Insurance code. It highlights the administrative action the DFS has taken against these agents, as well as whether the DFS referred any matters to the Division of Insurance Fraud for criminal investigation. The last section of Insights Enforcement Actions lists the names of the individuals and businesses against whom disciplinary action has been taken, including license suspension, revocation, probations, and fines.

You can view current and archive Insurance Insight newsletters at:

On Guard for Seniors Web Site

On Guard for Seniors helps seniors, their families, and caregivers avoid becoming victims of fraud or misleading sales tactics. The site provides information about annuities, reverse mortgages, long-term care insurance, and
identity theft. It lists key questions to ask when purchasing insurance and provides videos on how various insurance and financial products work. The website also includes a consumer alert section that highlights different financial schemes used to defraud seniors as well as success stories from seniors who sought help from the DF on these topics. To view the website you can go to:  
http://www.myfloridacfo.com/onguard/#.U0FPz01OU5s

**MyProfile**

MyProfile is the online Website for the Florida DFS’ Bureau of Licensing. Agents and agencies need to create a MyProfile account where they can do the following:

- View their licenses and appointments
- Verify name and address changes
- Apply for adjuster and agent licenses
- Apply for an agency license or update agency information
- View information about and any deficiencies in license applications
- Check their continuing education compliance status
- Print duplicate copies of their licenses
- Make payments

MyProfile also helps agents find approved continuing education courses for their specific lines of authority, and let’s insurance agencies terminate and make changes to the agent-in-charge, owner, and officer. Agents are also required to update the DFS about any changes to their phone numbers and home, business, or email addresses through their MyProfile account. To view go to: 
http://www.myfloridacfo.com/Division/Agents/Licensure/myProfilehelp/#.U0FQ7U1OU 5s

**Website**

The DFS maintains a website at www.myflorida.com where agents, consumers, and businesses can find information about DFS updates and news. The site also contains information about the specialized Divisions with the DFS, including the Agent and Agency Services and the Division of Insurance Fraud, and contains a link to each Division’s web page where agents can obtain more information about licensing requirements, industry alerts, and enforcement matters.

The DFS s homepage also includes the following links: Financial Guides for Seniors Updates about the CFO s initiatives (e.g., transparency Florida, fraud and consumer protection) Information about unclaimed property in the state Press releases issued by the DFS The State’s annual financial report Resources for Florida residents, such as consumer guides and how to report fraud In addition, the OIR also maintains a website at www.floir.com/ which contains important information about the Florida insurance industry, lists of companies that are authorized to transact insurance, and rate and form filings.

**Transparency Florida**

*Transparency Florida* allows consumers to track government spending and view finance reports, fund balances, state and local receipts and disbursements, and government contracts. The purpose of the website is to provide transparency regarding how the state government is managed and funded and to hold state legislatures accountable for how tax dollars are spent. For more information, you can visit: 
http://www.myfloridacfo.com/Transparency/

**Financial Frontlines**
**Financial Frontlines** provides information and resources to help Florida’s 58,000 military fight back against financial fraud and debt. This website contains information and videos that discuss the following topics:

- Identity Theft
- Service members Civil Relief Act
- Credit Scoring
- Budgeting and Savings
- Predatory Lending
- Financial planning for marriage, retirement, health care, college, homeownership, and other financial events

For additional information and to view the website go to:


**E. Guaranty Association**

**Florida Life and Health Insurance Guaranty Association (FLHIGA)** is a statutory entity created in 1979 when the Florida legislature enacted the Florida Life and Health Insurance Association Act according to F.S. Chapter 631 Sections 631.711 631.737 and 631.811 - 631.828.

The FLHIGA Act can be accessed on-line at a site sponsored by the Florida Senate. Go to www.flsenate.gov. On the Home Page, look for the section titled Laws. Find the Florida Statutes and scan down to Chapter 631 Part III. You can also visit the FLHIGA website at: http://www.flahiga.org/

**Members and Assessments**

FLHIGA is composed of all insurers licensed to sell direct life insurance, accident and health insurance, and certain annuities in the state of Florida. In the event that a member insurer is found to be insolvent and is ordered to be liquidated by a court, the FLHIGA Act enables FLHIGA to provide protection (up to the limits spelled out in the FLHIGA Act) to Florida residents who are holders of life and health insurance policies and certain annuities with the insolvent insurer.

**Powers and Duties of the Association** - According to F.S. § 631.717, if a domestic insurer is an impaired insurer, the association may, subject to the approval of the impaired insurer and the department:

- Guarantee or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the covered policies of the impaired insurer;
- Provide moneys, pledges, and guarantees, to assume payment of the insurer’s obligation; and
- Loan money to the impaired insurer.

If a member insurer becomes insolvent and is ordered to liquidate, a court will appoint a receiver to take over the insurer and wind up its affairs. FLHIGA will then assume the liabilities of the to Florida policyholders and will service the policies, collect premiums, and pay valid claims that become due. FLHIGA will also try to find another insurance company to take over the policies.

FLHIGA has a number of other powers, including the right to:

- **Enter into such contracts** as are necessary or proper to carry out the provisions and purposes of this part.
- **Sue or be sued**, including the taking of any legal actions necessary or proper for the recovery of any unpaid assessments under F.S. § 631.718, provided that service of process shall be made upon the person registered with the department as agent for receipt of service of process.
• **Borrow money** to affect the purposes of this part. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets.
• **Employ or retain such persons** as are necessary to handle the financial transactions of the association and to perform such other functions as become necessary or proper under this part.
• Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association.
• **Take such legal action** as may be necessary to avoid payment of improper claims.
• **Exercise**, for the purposes of this part and to the extent approved by the department, the **powers of a domestic life or health insurer**, but in no case may the association issue insurance policies or annuity contracts other than those issued to satisfy the contractual obligations of the impaired or insolvent insurer.

**FLHIGA Coverage of Liabilities**

FLAHIGA’s liability for the contractual obligations of the insolvent insurer shall be as great as, but no greater than, the contractual obligations of the insurer in the absence of such insolvency, but the aggregate liability of the association shall not exceed the following:

- $300,000 in life insurance death benefits
- $100,000 in life insurance cash surrender value
- $300,000 for health insurance claims
- $250,000 in annuity cash surrender value
- $300,000 in annuity benefits.

In no event shall the association be liable for any penalties or interest. Examinations and annual Reports

The DFS is responsible for regulating and examining the association.

By May 1 each year, the association’s board of directors must submit a financial report to the DFS, along with a report of its activities for the preceding year.

**Prohibited Advertising of Association**

It is an unfair trade practice for anyone to use the existence of the Florida Life and health Insurance Guaranty Association, or the protections the association offers, in order to sell insurance. However, insurers and agents are allowed to give policyholders and applicants written information prepared by the association that summarizes the claim, cash value, and annuity cash value limits of the association, if request.
Chapter Review Questions

1. The Office of Insurance Regulation (OIR) provides oversight for all of the following EXCEPT:
   a) Insurance companies licensed to do business in Florida
   b) Residual markets
   c) Joint Underwriting Association
   d) Unauthorized insurers

2. Licensed agents may not legally advertise or offer to act as an agent unless they are appointed by at least one entity.
   a) True
   b) False

3. Licenses must notify the DFS in writing of a change in their name, address, email, or phone number within no more than _____ days.
   a) 30
   b) 10
   c) 20
   d) 60

4. Advertising gifts are permitted under specific circumstances if the amount is:
   a) $25
   b) $100 in aggregate
   c) $500 in aggregate
   d) $10
II. Insurance Law and Updates

Overview and Learning Objectives

Changes and or additions in the Florida Insurance Code? And how will these changes affect the way an agent conducts his or her business. The recent changes to Florida’s insurance laws that agents must understand, including new continuing education requirements, application procedures, and change of address reporting, among other matters. The role of the federal government in the regulation of insurance industry

A. New Florida law updates

The state of Florida has made several important changes to the insurance laws and rules are discussed next. Including:

Change of Address Notification - According to F.S. § 626.551, licensees are required to notify the DFS of any name, address, phone, or email change within 30 days. Previously, licensees were required to notify the DFS within 60 days.

Proof of Pre-Licensing Education

Applicants for an agent’s application can now provide a statement in the application indicating what method they used to meet the required pre-licensing education experience, knowledge, or instructional requirements instead of submitting proof of completion of the required pre-licensing course. This change lets a person apply for a license while taking a pre-licensing course rather than having to wait to apply until after having completed the course. However, keep in mind, the DFS still cannot issue a license until the pre-licensing course is complete.

Beneficiary Designation of Non-Probate Assets in Divorce - According to F.S. § 732.703, upon divorce, dissolution, or invalidity of marriage a spouse who has been named the beneficiary under a non-probate assets, such as life insurance policy, TOD and POD accounts, annuities, IRAs, 401(k) plans, and other employee benefit plans will become null and void. If the provisions of F.S. § 732.703 apply, an asset will pass as if the former spouse predeceased the decedent. The law does not void a beneficiary designation:

- To the extent that federal or state law provides otherwise
- If the ex-spouse was designated as an irrevocable beneficiary
- If a person designates an ex-spouse as beneficiary after the divorce is final
- If a court order requires a person to maintain the asset for the benefit of a former spouse
- If the person remarries an ex-spouse and they remain remarried until the person’s death
- If an asset is held jointly in two or more names (and the death of one co-owner vests ownership of the assets in the surviving co-owner(s)).

Note: State-administered retirement plans are exempt from F.S. § 732.703.

Continuing Education Requirements - According to F. S. § § 626.261 and 626.281, new continuing education requirements will apply to agents with a compliance period ending on or after October 31, 2014. Agents who have been licensed for less than six (6) years must still complete 24 hours of continuing education every two years.
According to the new law, agents must complete a **five-hour law and ethics** update course as part of the 24-hour continuing education requirement. This course replaces the current ethics, law, premium discounts, and senior suitability requirements across the different license types. The new five-hour course must be specific to the agent’s license and must cover the following subject areas:

- Insurance law updates and other similar insurance related topics determined by DFS;
- Ethics for the insurance professional;
- Premium discounts;
- Determining suitability of products and services; and
- Disciplinary trends and case studies

Agents who have been licensed for six years or more and have gone through three compliance cycles will qualify for the 6-year reduction, which changes the continuing education requirement from 24 hours to 20 hours. A person who has been licensed as a 215 agent for 25 years or more and has a CLU designation may qualify for further continuing education reduction. These individuals must also complete the five-hour law and ethics course update during each compliance period ending October 31, 2014, or later.

Agents may carry forward excess continuing education hours that they have earned during one compliance period to the next compliance period. However, credits cannot be carried over for more than one compliance period.

Agents will not be able to renew their appointments, reinstate old ones, or obtain new ones if they have not complied with the continuing education requirements. The DFS may grant an extension of up to one year to complete the continuing education requirements, if good case is shown. Good cause might include events outside the agent’s control, such as a short-term disability, military duty, or illness. The DFS may impose a **$250 fine for failure to comply with the continuing education requirement** on a timely basis.

Note: Licensees who are on **active military duty** can request a waiver. Supporting documentation, such as written orders, must be submitted with the request. Agents should keep in mind that waivers will only be granted for the most recent compliance period and a new written request must be submitted for each additional period.

Previously, there was no military waiver for continuing education.

**2015 Legislative Update**

Some of the laws that affect applicants and licensees of the Department were changed in the 2015 legislative session. For more information, review **Chapter 2015-180** of the Laws of Florida. All laws shown are effective July 1, 2015.

**General Lines Agents Selling Health Insurance** – According to Sec. 626.015(5)(d), F.S. - general lines agents can transact health insurance with any health insurer they are appointed with. 

This means: The prohibition against general lines agents writing health insurance for companies other than those insurers that also sell property and casualty insurance was removed. No additional license will be required as general lines agents are required to study health insurance in the general lines pre-licensing course and take an exam that includes health insurance.

**Agent in Charge Licensing and Appointment Reductions** – According to Sec. 626.0428(4)(a), F.S. - an agency’s agent in charge will now only be required to hold a minimum of two license types for the lines of insurance transacted at the agency. However, if the agency sells only one line of insurance, the agent in charge must hold that license type.
Expansion in Licensing Requirement Exemptions – According to changes to sec. 626.221, F.S. and several other laws, expand pre-licensing and examination exemptions for some applicants, including:

- **Customer representative** - the pre-licensing course and examination will no longer be required. Applicants who have earned a degree which includes 9 hours of insurance instruction in areas specific to property and casualty insurance or hold certain designations specified in law will qualify.

- **General lines and all-lines adjuster licenses** - exempt from the pre-licensing course and examination for applicants who have an insurance degree and 18 hours of college credits in areas specific to property and casualty insurance, or if they hold the CPCU designation from American Institute for Chartered Property and Casualty Underwriters.

- **All lines adjusters** - the Associate in Claims (AIC), is added to the other designations which can exempt an applicant from the pre-licensing course and adjuster examination.

- **Personal lines** - exempts the pre-licensing course and examination for applicants who have any degree, if the degree included 9 hours of insurance instruction in areas specific to personal lines, or if they hold the CPCU designation from American Institute for Chartered Property and Casualty Underwriters.

- **Life, health, annuity and variable contract lines** - creates an exemption from pre-licensing course and the examination for applicants who hold any degree, if the degree included 9 hours of insurance instruction in the license area they are applying for, or if the applicant holds a CLU designation from the American College of Financial Services.

The Bureau of Licensing will review each applicant’s exemption criteria to determine whether applicants are eligible for exemption.

Pre-licensing Education
Sec. 626.2817(3), F.S. - clarifies that 75% of a pre-licensing course must be completed in order for a student to receive credit. This means a provider can certify a student as having “completed” a pre-licensing course provided the student attended 75% of the course. This does not mean a provider only has to teach 75% of the course.

Customer Representatives’ Compensation – According to sec. 626.753(1)(b), F.S. - allows agencies to pay customer representatives both salary and commissions instead of salary only. Also see Sec. 626.7354(3), F.S.  
**What this means:** customer representatives can be paid some commission as long as the commissions don’t exceed their base salary.

Applicant Requirements for Knowledge, Experience or Instruction – According to sec. 626.7851, F.S. - requires the coursework a life agent takes be specific to the lines of insurance the license authorizes them to sell. This includes life insurance, annuities, and variable contracts (which includes variable life insurance and variable annuities). Specifies that pre-licensing education courses for life agents, which are combined with another license type, must be a minimum of 60 hours in length.

Sec. 626.8311, F.S. - requires the coursework a health agent takes be specific to the lines of insurance the license authorizes them to sell. This includes all categories of health insurance.  
**What this means:** Standalone life or health courses will remain 40 hours; however, combination life and health courses must now be at least 60 hours and cover life insurance, annuities, variable products and health insurance.
Agent’s Records – According to sec. 626.748, F.S. - clarifies the law to require licensees to maintain records for five (5) years after policy expiration.

Recommendations to Surrender – According to sec. 627.4553, F.S. - defines the term "surrender" to exclude actions that are not intended to be covered by the law, and removes a reference to companies as the intent of the original law was to address improper agent conduct.

Requires that notification be given to the consumer by an agent in writing, rather than on a specific form created by the department.

Changes the requirement regarding the disclosure of tax consequences by insurance agents.

2018 Legislative Update

Insurance HB 465 Effective Date: 3/30/2018

The bill makes a number of changes to insurance by providing an exception from valuation rules for stocks in subsidiaries for certain foreign insurers under certain conditions; repealing the requirement that FLSO submit written requests to OIR for eligibility purposes; revising requirements for rules adopted by the Department of Financial Services and the Financial Services Commission relating to the privacy of certain consumer information; providing that an insurer may elect to issue an insurance policy without being executed by one of the specified insurer representatives; requiring that an insurer summarize policy changes on the required notice upon renewal; permitting use of the Intelligent Mail barcode, or similar method approved by the United States Postal Service, to be used to establish proof that required motor vehicle insurance notices of cancellation, non-renewal, or transfer of insurer were mailed; adding viatical settlement providers to the list of specialty insurers and allowing any specialty insurer to overcome the presumption of control by filing with OIR a disclaimer of control on an OIR form or a copy of their SEC Schedule 13G; and requiring motor vehicle service agreement companies and health maintenance organizations (HMO) to deliver motor vehicle service agreements and HMO contracts in compliance with the standards applicable to insurers, etc.

Unfair Insurance Trade Practices HB 483 Effective Date: 7/1/2018

The bill revises types, value & frequency of advertising & promotional gifts that licensed insurers or their agents may give to insureds, prospective insureds, or others. The bill authorizes such insurers or agents to make certain charitable donations on behalf of insureds or prospective insureds. The bill prohibits title insurance agents, agencies, & insurers from giving insureds, prospective insureds, or others merchandise in excess of specified value. The bill authorizes certain licensed insurers & agents to give specified complimentary services or discounted rates on specified services.

Direct Primary Care Agreements HB 37 Effective Date: 7/1/2018

The bill specifies that a direct primary care agreement does not constitute insurance & provides requirements for such agreement.

Workers’ Compensation Benefits for First Responders SB 376 Effective Date: 10/1/2018
The bill provides that, under certain circumstances, posttraumatic stress disorder suffered by a first responder is an occupational disease compensable by workers’ compensation benefits. The bill specifies that benefits do not require a physical injury and are not subject to certain apportionment or limitations, etc.

**Unfair Insurance Trade Practices HB 533** Effective Date: 7/1/2018

The bill authorizes certain insurers to refuse to insure or continue to insure applicant or insured for failing to purchase certain noninsurance motor vehicle services.

**Homeowners’ Insurance Policy Disclosures HB 1011** Effective Date: 1/1/2019

The bill provides & revises homeowner’s flood damage insurance policy disclosure requirements.

**B. Pertinent Federal law review pertinent to Florida licensed insurance professionals**

**Federal Law Review Pertinent to Florida Licensed Insurance Professionals**

Most regulation of the insurance industry is done at the state level. This practice was validated in 1869 in the United States Supreme Court case of Paul v. Virginia (8 Wall 168 (1869)). In Paul, the Court upheld a Virginia statute requiring out-of-state insurers and their agents to obtain a license before conducting business within the state. The Court held that insurance was not commerce within the meaning of the Commerce Clause, and therefore, states held exclusive regulatory authority over the business of insurance.

**Role of the Federal Government**

For 75 years following the Paul decision state authority over insurance regulation was unquestioned. The states created a vast and pervasive network of laws, regulations, taxes, and cooperative accounting practices. Many states enacted legislation based on model acts of the National Association of Insurance Commissioners (NAIC), an organization composed of the chief insurance regulatory officials of the 50 states, the District of Columbia, and the U.S. territories. The states’ adoption of these model acts helped to establish a measure of uniformity in the states’ regulation of insurance. However, in 1944 the Supreme Court reviewed its decision in Paul in United States v. South-Eastern Underwriters Association (322 U.S. 5433 (1944)). The South-Eastern Underwriters Association, a rate making organization, was charged with restraining commerce in violation of the Sherman Antitrust Act by fixing and enforcing arbitrary and noncompetitive premium rates. The Supreme Court rejected South-Eastern’s claim that the Sherman Anti-Trust Act did not apply because, under Paul, insurance is not commerce. The Court reversed its holdings in Paul and ruled that insurance is commerce, and when transacted across state lines, it is interstate commerce subject to federal law, including the Sherman Antitrust Act. As a result of (Paul), the constitutionality of all states statutes regulating the insurance business was called into question and a state of confusion reigned. Congress, unlike the states, had passed no laws specifically regulating the business of insurance.

**McCarron-Ferguson Act**

Then in 1945, Congress responded to the South-Eastern Underwriters Association case by enacting the McCarran-Ferguson Act of 1945, declaring in the Act “the continued regulation and taxation by the several States of the
The business of insurance is in the public interest.” The Act granted states the power to regulate the business of insurance, removing all Commerce Clause limitations on the states’ authority in this area. Congress’ authority to delegate this power to the states under the Commerce Clause was upheld by the Supreme Court in the 1946 case of Prudential Ins. Co. v. Benjamin.

A provision in the McCarron-Ferguson Act would permit the federal government to resume control over the regulation of the business of insurance if state regulation becomes inadequate. The McCarron-Ferguson Act allows Congress to enact legislation invalidating, impairing, or superseding state law, if the legislation “specifically relates to the business of insurance (15 U.S.C. 1012 (b)). And that is what happened after the financial crisis in 2008. Congress passed the Dodd–Frank Wall Street Reform and Consumer Protection Act of 2010 which created the Federal Insurance Office (FIO).

The Federal Insurance Office

The Federal Insurance Office (FIO) was established by Title V of the Dodd-Frank Wall Street Reform and Consumer Protection Act (DFA). The FIO is housed in the Department of the Treasury and is headed by a Director who is appointed by the Secretary of the Treasury. While the FIO serves an important role by providing necessary expertise and advice regarding insurance matters to the Treasury Department and other federal agencies, it is not a regulatory agency and its authorities do not displace the time-tested robust state insurance regulatory regime.

Scope and Functions

The FIO’s authorities extend to all lines of insurance other than health insurance, long-term care insurance (except that which is included with life or annuity insurance components) and crop insurance, which is governed by the Federal Crop Insurance Act. The FIO does not have supervisory of regulatory authority over the business of insurance. The FIO is charged with monitoring all aspects of the insurance sector, including identifying activities within the sector that could potentially contribute to a systemic crisis to the broader financial system, the extent to which under-served communities have access to affordable insurance products, and the sector’s regulation. The Director of the FIO serves as a non-voting member of the Financial Stability Oversight Council (FSOC). He also plays a role in the resolution of certain troubled insurance companies. The FIO advises the Secretary of the Treasury on major domestic and prudential international insurance matters. The FIO has authority to represent the U.S. federal government internationally at meetings of the International Association of Insurance Supervisors (IAIS) and other similar organizations. However, state insurance regulators, either directly or through their NAIC representatives, present the views of the insurance regulatory community internationally.

Powers

In order to carry out these functions, the FIO is authorized to receive and collect data and information on the insurance industry and can enter into information sharing agreements with state regulators. The FIO can also require an insurer or its affiliate to submit data to the office; however, the FIO must first determine whether any public or regulatory sources are available before requiring such information directly from an insurer. The law provides an exemption for small insurers that meet a minimum size threshold not yet defined by the FIO.

Reports

A primary function of the FIO is to issue several one-time reports as well as annual reports to Congress. In December 2013, the FIO’s released its study on “How to Modernize and Improve the System of Insurance Regulation in the United States.” A listing of available reports can be found on the U.S. Department of the Treasury/FIO Webpage.

SEC/FINRA Insurance Regulation
Some insurance products are regulated by both federal and state government. For example, the Securities Exchange Commission (SEC) and the Office of Financial Regulation Division of Securities (FINRA) regulate variable insurance contracts. Variable life insurance and variable annuity contracts are insurance company products, but these products present a degree of investment risk to the buyer and accordingly, they have also been identified as securities in accordance with SEC regulations.

With the proliferation of the sales of both variable life insurance and variable annuities over the past several years many state and federal regulators have been concerned about the sales of these variable products to unsuitable consumers. Recently, both the SEC and FINRA recommended new regulations to protect seniors (age 65 and older) from deceptive sales practices (unsuitability) of both fixed and variable annuities.

And of course as part of the Dodd-Frank Wall Street Reform and Consumer Protection Act, specifically Title IX, subtitle I, Section 989a, relating to senior investment protections, it calls on the state’s to adopt suitability requirements that meet or exceed National Association of Insurance Commissioners’ Suitability in Annuity Transaction Model Requirements to be required for a state to participate in a program of grants to support enhanced protections of seniors against misleading marketing practices. Additionally, under the Dodd-Frank Title IX, subtitle I, Section 989J of the Dodd-Frank Act Florida’s adoption of at least the minimum requirements NAIC Suitability in Annuity Transactions Model is necessary for Florida’s continued jurisdiction over indexed securities.

FINRA

The Financial Industry Regulatory Authority (FINRA) is the largest non-governmental regulator for all securities firms doing business in the United States. All told, FINRA oversees nearly 5,000 brokerage firms, about 173,000 branch offices and approximately 659,000 registered securities representatives.

Created in July 2007 through the consolidation of NASD and the member regulation, enforcement and arbitration functions of the New York Stock Exchange, FINRA is dedicated to investor protection and market integrity through effective and efficient regulation and complementary compliance and technology-based services.

FINRA touches virtually every aspect of the securities business—from registering and educating industry participants to examining securities firms; writing rules; enforcing those rules and the federal securities laws; informing and educating the investing public; providing trade reporting and other industry utilities; and administering the largest dispute resolution forum for investors and registered firms. It also performs market regulation under contract for The NASDAQ Stock Market, the American Stock Exchange, the International Securities Exchange and the Chicago Climate Exchange.

The new consolidated FINRA Rules approved by the SEC (Notice 09-25) to adopt rules governing know-your-customer (FINRA Rule 2090), suitability (FINRA Rule 2111) obligations for the consolidated FINRA rulebook, as well as FINRA Rule 2330 on the suitability sale of variable annuities.

FINRA Rule 2090 Know Your Customer Rule

In general, the new FINRA Rule 2090 (Know Your Customer) is modeled after former NYSE Rule 405(1) and requires firms to use “reasonable diligence,” in regard to the opening and maintenance of every account, to know the “essential facts” concerning every customer. The rule explains that “essential facts” are “those required to:

- Effectively service the customer’s account,
- Act in accordance with any special handling instructions for the account,
- Understand the authority of each person acting on behalf of the customer, and
- Comply with applicable laws, regulations, and rules.”
The **know-your-customer** obligation arises at the beginning of the customer-broker relationship and does not depend on whether the broker has made a recommendation. Unlike former NYSE Rule 405, the new rule does not specifically address orders, supervision or account opening-areas that are explicitly covered by other rules.

**FINRA Rule 2111**

FINRA Rule 2111, is the new suitability rule, generally it is modeled after former NASD Rule 2310 and requires that a firm or associated person have a reasonable basis to believe that a recommended transaction or investment strategy involving a security or securities is suitable for the customer, based on the information obtained through the reasonable diligence of the member or associated person to ascertain the customer’s investment profile. The rule further explains that a customer’s investment profile includes, but is not limited to: the customer’s age, other investments, financial situation and needs, tax status, investment objectives, investment experience, investment time horizon, liquidity needs, risk tolerance, and any other information the customer may disclose to the member or associated person in connection with such recommendation. The new rule continues to use a broker’s recommendation as the triggering event for application of the rule and continues to apply a flexible facts and circumstances approach to determining what communications constitute such a recommendation. The new rule also applies to recommended investment strategies, clarifies the types of information that brokers must attempt to obtain and analyze, and discusses the three main suitability obligations (discussed below). Finally, the new rule modifies the institutional investor exemption in a number of important ways.

**FINRA Rule 2330**

FINRA consolidated the old Rule 2821 on deferred variable annuities into FINRA Rule 2330. The new consolidated FINRA Rule 2330 establishes sales practice standards regarding recommended purchases and exchanges of deferred variable annuities. The rule has the following six main sections:

1. General considerations, such as the rule’s applicability;
2. Recommendation requirements, including suitability and disclosure obligations;
3. Principal review and approval obligations;
4. Requirements for establishing and maintaining supervisory procedures;
5. Training obligations; and
6. Supplementary material that addresses a variety of issues ranging from the handling of customer funds and checks to information gathering and sharing.

**Other Licensing Changes**

According to F.S. 626.536 and 626.641, an agent whose license was suspended or revoked cannot transact business requiring an insurance license or own, control, or be employed by an insurance entity licensed by the DFS. This prohibition has been extended until an agent’s license has been reinstated or a new license has been issued.

Agents are also required to notify the DFS of any administrative actions taken against them by a Florida governmental agency or governmental agency in another state or jurisdiction. This requirement has been expanded so that agents must report any action taken against them by other regulatory agencies as well (in addition to actions taken by governmental agencies). Federal Law Review Pertinent to Florida Licensed Insurance Professionals Most regulation of the insurance industry is done at the state level.
This practice was validated in 1869 in the United States Supreme Court case of Paul v. Virginia (8 Wall 168 (1869)). In Paul, the Court upheld a Virginia statute requiring out-of-state insurers and their agents to obtain a license before conducting business within the state. The Court held that insurance was not commerce within the meaning of the Commerce Clause, and therefore, states held exclusive regulatory authority over the business of insurance.

Chapter 2 Review Questions

1. Agents can carry forward excess CE hours:
   (Page 33)
   a) To the next CE period
   b) To the next 2 CE periods
   c) To any number of CE periods
   d) Cannot carry forward any credits at all

2. The McCarron-Ferguson Act provided regulation and taxation by:
   (Page 34)
   a) States only
   b) Federal governments only
   c) Both State and Federal governments
   d) Neither the State nor Federal governments

3. The Federal Insurance Office (FIO) was established by:
   (Page 35)
   a) McCarron Ferguson Act
   b) Dodd-Frank
   c) The U.S. Supreme Court
   d) Sherman Anti-Trust Act

4. Agents _________________ must complete 20 hours of continuing education every two years.
   (Page 33)
   a) Licensed for 6 years or less
   b) Licensed for 4 years or more
   c) Licensed for 5 years or more
   d) Licensed for 6 years or more
III. Ethical requirements

Overview and Learning Objective

Over the past decade unethical marketing practices in the insurance industry, at both the corporate level and in the field, has come to the attention of both federal and state regulators. Insurance producers, are responsible for supporting and advancing the business of insurance through proper, principled, and ethical practices. It is important to remember that no other industry depends more on trust than the insurance industry. Insurers and agents need to rebuild that trust.

Agents must have an understanding of the ethical requirements for Florida licensed insurance professional in the marketing and sales of life insurance products. This chapter also examines the new suitability requirements under the new Florida Suitability Law, as well as the Florida Unfair Marketing Practices of Competition and Unfair or Deceptive Acts, and examine the types of premium discounts that insurers may offer to applicants.

Ethical Guidelines

No one would purchase insurance if they did not trust that the insurance company would be in business at a later date to pay out a benefit. To earn and keep that trust, insurers and agents must embrace the principles of ethical marketing and ethical service standards. One way of doing that is to follow a code of ethics.

Nature of Ethics

The important points addressed in this lesson are:

- Humans are social animals - we don’t exist alone - therefore, an ethical system is necessary.
- Of the two methods available to resolve disagreements - force and reason - reason provides the best possible outcome for society
- The Golden Rule has been adopted by most of the world’s religions as a cornerstone of their ethical framework.
- Compliance and ethics are closely related concepts, but they are not identical.
- Professions are characterized by specialized knowledge and an ethical code to which members are expected to adhere.

What are Ethics?

Most of us, we are raised in social groupings and live our entire lives in social settings. Ostracism or exile is one of the harshest punishments imaginable, whether it is a formal banishment or simply that our social clique no longer considers us “part of the old gang”. Most of us like to think that we are civilized. But that word, "civilized", simply means to live in a city - that is to say, among many other fellow human beings. Which raises a point that has been addressed by philosophers from time immemorial: "How are we supposed to treat those we live with, and how should we expect them to treat us?"

We will examine the nature of ethics, consider the parties to whom the agent owes an ethical duty, and identify a few ethical yardsticks against which our actions can be measured.

In practical terms, ethics is a system or code of principles that directs our actions towards others. Before trying to apply the precepts of any ethical system to the complex and important job of the financial services agent, it seems sensible to look somewhat deeper into this system that we know as ethics and understand the principles on which
it is based. Not surprisingly, the foundational ethical standards that apply to the financial services agent in his or her interaction with customers or represented companies are the same that serve as the building blocks of the earth's great religions: the **Golden Rule**. The Golden Rule maintains that each of us should treat others as he or she would wish to be treated.

A. **Code of ethics DFS Rule Chapters 69B-215, 220, 221, and 230, F.A.C.**

The *Florida Code of Ethics* will apply standards of conduct designed to avoid the commission of acts or the existence of circumstances which would constitute grounds for suspension, revocation, or refusal of license, and to avoid the use of unfair trade practices and unfair methods of competition which would be in violation of state laws. All applicants for licenses as life agents must subscribe to the code of ethics.

According to F.S. § 626.797, and F. S. § 626.79, the DFS has set forth broad guidelines to govern the conduct of life agents in their relations with the public, other agents, and insurers.

B. **Marketing regulatory and ethical guidelines for Florida licensed insurance professionals**

To accomplish this goal, agents must:

- Understand and observe the laws governing life insurance;
- Accurately present facts that impact clients’ decisions;
- Be fair when working with colleagues and competitors; and
- Always place the policyholders’ interest first.
- Defamation

**NAIFA Code of Ethics**

The *Florida Department of Financial Services* encourages all licensed agents to embrace the code of ethics set forth by the National Association of Insurance and Financial Advisors (NAIFA). One of the oldest and largest trade organizations in the insurance field, NAIFA was founded on June 18, 1890 in Boston as the National Association of Life Underwriters and today has over 70,000 members across the country. Serving to protect and promote the critical role of insurance and the role of professional agents and advisors, NAIFA advocates the following Code of Ethics and related responsibilities:

Those engaged in offering insurance and other related financial services occupy the unique position of liaison between the purchasers and suppliers of insurance and closely related financial products. Inherent in this role is the combination of professional duty to both the client and the company. Ethical balance is required to avoid any conflict between these two obligations.

Therefore, I Believe It To Be My Responsibility:

- To hold my profession in high esteem and strive to enhance its prestige.
- To fulfill the needs of my clients to the best of my ability.
- To maintain my clients’ confidences.
- To render exemplary service to my clients and their beneficiaries.
- To adhere to professional standards of conduct in helping my clients to protect insurable obligations and attain their financial security objectives.
- To present accurately and honestly all facts essential to my clients' decisions.
To perfect my skills and increase my knowledge through continuing education.
To conduct my business in a way that might help raise the professional standards of those in my profession.
To keep informed with respect to applicable laws and regulations and to observe them in the practice of my profession.
To cooperate with others whose services are constructively related to meeting the needs of my clients.

Life insurance agents doing business in the state of Florida are bound by the Code of Ethics, which describes certain activities as unlawful in the insurance business. Agents are also encouraged to follow the NAIFA Code of Ethics, which imposes general ethical duties when working with clients and other in the profession. Ethical codes recognize that agents occupy positions of confidence and public trust, and must maintain high ethical standards at all times when interacting with clients.

In addition to the specific practices prohibited by these codes, insurance agents must also keep in mind the other general ethical practices, such as:

- Conducting business with clients, prospects, and other industry professionals according to high standards of honesty and fairness;
- Efficiently handling business, including complaints and disputes;
- Providing informed and client-focused service; and
- Engaging in fair competition and trade practices.

C. Understanding industry products & suitability of sales and services

Suitability should be a concept that is familiar to all of us. Whether it is a routine purchase or a life decision, we are always assessing our choices based upon what best suits our needs. The topic is no different in the world of insurance. When an insurance agent carefully aligns a client’s needs and objectives with a life insurance or annuity product, we can conclude that the sale is suitable.

According to LIMRA’s (Life Insurance Marketing Research) Producer Guide to Market Conduct, a suitable life insurance or annuity sales is one that is appropriate for the customer in light of his or her total financial situation—one that balances adequate coverage with affordability.

To determine suitability, an insurance agent must strive to answer the following questions:

- What are the client’s needs?
- What product or products best met those needs?
- Does the client understand the product and its provisions?
- Does the client understand and accept the product’s limitations?
- Does the product service the client’s interest, and does the product advance the client’s objectives?

When an insurance agent carefully aligns a client’s needs and objectives with a life insurance or annuity product, we can conclude that the sale is “suitable”. According to LIMRA’s (Life Insurance Marketing Research) Producer Guide to Market Conduct, “a suitable life insurance or annuity sales is one that is appropriate for the customer in light of his or her total financial situation—one that balances adequate coverage with affordability.”
However, like any industry there will always be a few bad apples that try to take advantage of a situation and put their own interests first. Regretfully, because of these few rogue salespersons, the Florida legislature passed a number of bills to protect consumers from unsuitable sales of life insurance and annuity products. Many of the bills followed the **Suitability Model Regulations** developed by the **National Association of Insurance Commissioners (NAIC)**.

**The Florida Annuity Transaction Model Regulation: Senate Bill 2994**

Back on July 1, 2004, the Florida legislators signed into law, Senate Bill 2994, which created F.S. § 627.4554, known as the **Florida Annuity Suitability Model**. The Bill provides standards and procedures, similar to the **2003 NAIC Suitability Model**, that agents and insurers must follow when recommending purchases and or exchanges of annuity products to seniors (those citizens age 65 and above).

Under the **Florida Annuity Suitability Model**, the agent or insurer must make “*reasonable efforts*” to obtain the following information about the senior’s financial status, tax status, and objectives prior to completing the sale of an annuity. Additionally, the agent or insurer must have “*reasonable grounds*” for recommending the annuity based on facts disclosed by the senior consumer as to his or her investments, other insurance products, financial situation, and needs.

The DFS indicated that the “*reasonable grounds*” standard in Florida law is a subjective standard. It requires the DFS to prove, by clear and convincing evidence, that an agent did not believe a transaction was suitable. The issue is not whether the investment advice was suitable on an objective basis but whether the agent believed it was. The DFS provides an example where an elderly couple living in Titusville, Florida, was convinced to invest their entire liquid net worth of $40,000 into deferred annuity investments. The agent did not disclose the features of the investment, including the many years of surrender charges that would prevent the couple from having access to their funds for the rest of their natural lives. The agent was asked what his reasonable grounds were for believing the investment was suitable. The agent responded that he had made inquiry of the consumers at the time of the transaction and determined that their health and finances were stable, and therefore, had reasonably believed the investment transaction was suitable.

These kinds of complaints continued and the DFS during its fiscal year of 2006 through 2007 opened 351 investigations related to annuity transactions, a 41 percent increase over the prior year. In the first eight months of fiscal year 2007 to 2008, the Department of Financial Services opened 206 annuity-related investigations—a 12.5 percent increase since the 2005 to 2006 period.

The DFS petitioned the Florida legislature to review the current Suitability Model due to the number of complaints and investigations, and provide stricter standards to protect senior consumers from predatory marketing practices and unsuitable product recommendations. The result was Senate Bill 2082.

**The John and Patricia Seibel Act: Senate Bill 2082**

In 2008, Florida lawmakers reviewed Florida’s current version of the **Suitability Model** to see whether they should amend the Suitability Model to meet the amended **2006 NAIC Suitability Model**. This Model set suitability requirements for agents and insurers to follow when selling annuities to consumers of any age, not just those ages 65 and older. Ultimately, the Florida legislators declined to adopt the NAIC new amendments. Rather, they enhanced the existing standards by which an agent must:

- Determine the suitability of annuity transactions with seniors,
- Convert a subjective measure to an objective standard for determining whether the agent properly applied these standards,
- Require that the agent’s suitability analysis be documented, and
Invoke other procedures

The result was the unanimous passage of Senate Bill 2082, signed into law on June 30, 2008, by then Governor Charlie Crist as Chapter 2008-237 Laws of Florida, also known as the “John and Patricia Seibel Act”. Named after a Venice, Florida couple in their 80s who were sold $600,000 worth of annuities that could not be touched without large penalties for 15 years, the new law significantly modifies the Florida Insurance Code with regard to sales of life insurance and annuities. The final version of the bill became effective January 1, 2009. The intent of the “Seibel Act” was to strengthen the standards for making annuity recommendations to senior consumers (age 65 or older) and imposing suitability guidelines and increasing penalties.

Reasonable Grounds Basis vs. Objective Reasonable Basis

Prior to the enactment of the Seibel Act, the DFS indicated the “reasonable grounds” standard in the Florida Suitability Model law was a subjective standard. It required the DFS to prove by clear and convincing evidence, that an agent did not believe a transaction was suitable. Thus, the issue was not whether the investment advice was suitable on an objective basis but whether the agent believed it was.

As the DFS maintained and as legislators agreed, “reasonable grounds” proved to be difficult to prove, disprove, or counter. In turn, such subjectivity made enforcement measures difficult for the department. Consequently, the “Seibel Act” changed the wording of the law to impose an objective standard for suitability, which now provides agents and regulators with more precise guidelines by which recommendations can be made and evaluated. According § 627.4554(4)(a) F.S., the language of the Act now reads:

“In recommending to a senior consumer the purchase or exchange of an annuity that results in another insurance transaction or series of insurance transactions, an insurance agent, or an insurer if no insurance agent is involved, must have an objectively reasonable basis for believing that the recommendation is suitable for the senior consumer based on the facts disclosed by the senior consumer as to his or her investments and other insurance products and as to his or her financial situation and needs.”

The result, the law revised the standard for assessing suitability from “reasonable grounds” to an objective reasonable basis.

Other Key Provisions of SB 21082

Some of the other key provisions of Senate Bill 20182 include the following:

- Expanded the “free look” period in all cases from 10 to 14 days [Ch. 2008-237, Fla. Laws, Section 8].
- Life insurance policies can avoid the “free look” requirement if prospective purchasers receive “a buyer’s guide and contract summary” prior to the insurer’s acceptance of an initial premium deposit.
- Prospective purchasers of all annuities, not just fixed annuities, must be given the buyer’s guide and contract summary required by the NAIC.
- All annuity purchasers must have the right to an unconditional refund “for a period of at 14 days.”
- Persons licensed to solicit or sell life insurance in Florida on or after January 1, 2009, must complete a minimum of three (3) hours continuing education in life insurance and annuity suitability [Ch. 2008-237, Fla. Laws, Section 3.].
- Licensees are required to provide their telephone number or email address and to keep this information accurate or face a $500 fine.
- Section 11 of the Seibel Act amends Section 627.805, Fla. Stat., to provide that Florida’s securities regulator, namely the Office of Financial Regulation (“OFR”), “shall regulate the sale of variable and indeterminate value contracts” as securities. As a result, life insurance agents in Florida must be
registered as associated persons of a securities dealer in order to sell variable annuities (or any other insurance product deemed a “security”) “in or from offices in this state.”

- The Act especially in combination with Chapter 2008-66, Laws of Florida (CS/CS/SB 2860), the “Homeowner’s Bill of Rights Act,” Florida has significantly increased penalties for violations of the Florida Unfair Insurance Trade Practices Act. For example, an insurer can now face an administrative fine of $40,000 for a single willful violation up to an aggregate fine of a quarter of a million dollars, instead of $20,000 and $100,000 respectively under current law. After the effective date of the Seibel Act, insurers may face even greater administrative penalties under the new powers granted to order rescission.

- Agents are also subject to increased fines for specified violations: $5,000 for each non-willful violation (increased from $2,500), up to a maximum aggregate amount of $50,000 (increased from $10,000). Willful violations can be punished administratively by a fine of $30,000 for each offense (increased from $20,000), up to a maximum aggregate amount of $250,000 (increased from $100,000).

- The prohibited practices punishable by these enhanced penalties are “Twisting,” & “Churning” and two new offenses created by the Seibel Act.
  - “Twisting” is prohibited by Section 626.9541(1)(l), Fla. Stat. It involves the use of misrepresentations, incomplete or fraudulent comparisons, and material omissions to sell insurance or to induce other actions.
  - “Churning” is prohibited by Section 626.9541(1)(aa), Fla. Stat. It occurs when a policyholder is fraudulently induced to use the value of existing insurance to purchase another product from the same insurer, when this increases compensation of the agent, but does not benefit the policyholder.

Florida 2010 NAIC Model Regulation: Senate Bill 166

On June 14, 2013, Governor Rick Scott signed into law, Senate Bill 166, which expands the application of annuity recommendation standards provided in F.S. § 627.4554 to all consumers. The bill also incorporates the 2010 NAIC Suitability in Annuity Transactions Model Regulation on annuity protections, broadens the scope of coverage to include all annuity transactions, and imposes additional duties on agents and insurers. The effective date of the bill is October 1, 2013. Key provisions of the bill are summarized below.

Producer Training

Florida’s law requires insurers to establish standards for training producers in the insurer’s annuity products. The insurer must verify that producers complete their product-features training before they present the insurers’ products to their clients.

Annuity Surrender Charges

The surrender charge of an annuity contract issued to a senior consumer age 65 or older may not exceed ten (10) percent, and the surrender charge period may not exceed ten (10) years. This restriction does not apply to IRAs and qualified plans, or to consumers with annual incomes over $200,000 or net worth over a million dollars (Accredited Investors).

Andrew McMillan of West Palm Beach was the caretaker of her parents, both of West Palm Beach, who were both suffering from the infirmities of aging (Alzheimer’s disease). Her father passed away on November 18, 2012. In June of 2012, Andrea McMillan discovered and reported to the Division of Insurance Fraud that her (separated) husband Brent Deviney forged annuity surrender forms for annuity accounts at Lincoln Financial Group, forged checks from account(s) at Wachovia Bank, and had also compromised account(s) at Merrill Lynch that were all in the names of her parent’s mental and physical condition and that she had Power of Attorney over her parents’ affairs and finances since 2004. At the time of the suspected offense Deviney was employed as a Registered
Representative by Newbridge Securities Corporation then located at 777 South Flagler Drive, Suite 602, East Tower, in West Palm Beach, Florida.

Investigation revealed that Deviney had compromised the accounts of his in-laws and converted approximately $200,000 to his own use.

Deviney was arrested on April 10th, 2013 on three counts of Exploitation of the Elderly, Florida Statute 825.103.

Recordkeeping

The producer must, at the time of sale, make a record of any recommendation made to a purchaser. The record must contain the information collected from the consumer and any other information used to make the recommendation. The producer must be able to provide. The insurer or the insurance commissioner with records for five years after the transaction is completed or as long as the annuity is in force with the insurer, whichever is longer. Producers may not dissuade consumers from truthfully responding to an insurer's request for confirmation of suitability information, filing a complaint or cooperating with the investigation of a complaint.

Insurer’s Suitability Supervision

Insurers must supervise the suitability of their producers' sales and may not issue an annuity unless there is a reasonable basis to believe it is suitable, based on the consumer’s suitability information. Insurers must review the suitability of every recommendation, either in-house or by contracting with a third party. Insurers must also maintain procedures to detect — before or after policy issue and delivery — any unsuitable recommendations. This monitoring may include confirmation of consumer suitability information through customer interviews, confirmation letters or other means. The law requires every insurer to report annually to its senior management on the effectiveness of its suitability supervision system, the exceptions discovered, and any corrective action taken.

Penalties

The DFS may order an insurance company, agency or producer to take corrective action for any consumer harmed by the insurance producer's violation of this law. Penalties are determined by the DFS under Florida law. A producer who submits unsuitable annuity recommendations to the insurer may be subject to termination of his or her sales appointment with the insurer.

Safeguard Our Seniors Act: Senate Bill 2176

Senate Bill 2176 entitled the Safeguard Our Seniors Act—strengthens regulations governing the sale of annuities to senior consumers. This bi-partisan achievement is the culmination of a three-year push by Florida’s CFO Alex Sink, to finally, put “alligator teeth” in Florida’s senior investor fraud laws to deter senior scammers. The law became effective January 1, 2011.

Summary of SB 2176

The Safeguard Our Seniors Act provides the following safeguards: Increased Penalty Provisions

- Classifies as a third degree felony the commission of fraud, including the unfair insurance trade practices known as twisting and churning, in connection with the offer, sale or purchase of financial products when the victim is 65 years of age or older. The bill exempts a number of fraudulent practices that are already prohibited.
• According to F. S. 626.641(3)(b), it prohibits the DFS from issuing a license to a former licensee who has had his or her license revoked resulting from the solicitation or sale of an insurance product to a senior consumer. If a licensee as an agent or customer representative or the eligibility to hold such a license has been revoked resulting from the solicitation or sale of an insurance product to a person 65 years of age or older, the DFS may not thereafter grant or issue any license under this code to such an individual.
• According to F.S. 626.621, it authorizes the DFS from granting a license to an agent or customer representative whose license has been revoked due to the solicitation or sale of an insurance product to a person 65 years of age or older.
• According to F. S. 627.4554(5)(b)(c), it authorizes the DFS to require an agent to make monetary restitution to a senior consumer harmed by a violation of the insurance code under certain circumstances. Also requires DFS to order payment of restitution to a senior consumer who is deprived of money by an insurance agent’s misappropriation, conversion, or unlawful withholding of the senior consumer’s money in the course of an annuity transaction.
• Classifies third-party marketers as affiliates of an agent if the marketer aids or abets the licensee in an insurance code violation involving the sale of an annuity to a senior.
• Specifies that the failure of an agent to make reasonable efforts to ascertain a consumer’s age is not a defense to an unfair insurance trade practice violation.
• Permits the taking of a video deposition of a senior citizen who is the victim of an unfair trade practice violation, which may be used in F. S. Chapter 120, administrative hearings.

The bill substantially amends F.S. Sections 624.310, 626.025, 626.621. 626.641, 626.798, 626.9521, 626.99, and 627.4554, and creates F.S. Section 817.2351.

i. Suitability information means information that is reasonably appropriate to determine the suitability of a recommendation, including:

Suitability Information

In recommending an annuity to a prospective purchaser, the insurance producer must have reasonable grounds for believing that the recommendation is suitable for the consumer based on the facts disclosed during the sale.

FINRA Rule 2111, is the new suitability rule, generally it is modeled after former NASD Rule 2310 and requires that a firm or associated person “have a reasonable basis to believe” that a recommended transaction or investment strategy involving a security or securities is suitable for the customer, based on the information obtained through the reasonable diligence of the member or associated person to ascertain the customer’s investment profile.” The rule further explains that a “customer’s investment profile includes, but is not limited to:

1. Age
2. Annual income
3. Financial situation and needs, including the financial resources used for the funding of the annuity
4. Financial experience
5. Financial objectives
6. Intended use of the annuity
7. Financial time horizon
8. Existing assets, including investment and life insurance holdings
9. Liquidity needs
10. Liquid net worth
11. Risk tolerance; and
12. Tax status

The new rule continues to use a broker’s “recommendation” as the triggering event for application of the rule and continues to apply a flexible “facts and circumstances” approach to determining what communications constitute such a recommendation. The new rule also applies to recommended investment strategies, clarifies the types of information that brokers must attempt to obtain and analyze, and discusses the three main suitability obligations. Finally, the new rule modifies the institutional-investor exemption in several important ways.

**Producer’s Belief an Annuity Is Suitable**

As a result of the suitability analysis, the producer must have a reasonable basis to believe that all the following points are true:

- The consumer has been reasonably informed of the various features of the annuity, such as:
  - Surrender charge period and amounts
  - Potential tax penalties associated with a sale, exchange, surrender or annuitization of the annuity
  - Expenses and investment advisory fees
  - Features of and potential charges for riders
  - Limitations on interest returns
  - Insurance and investment components
  - Market risk
- The consumer would benefit from the annuity's features.
- The annuity as a whole, including any riders or product enhancements, is suitable for the consumer based on his or her suitability information. In the case of an exchange or replacement, the transaction as a whole is suitable.
- An exchange or replacement (if applicable) is suitable taking into consideration, among other factors, whether the consumer:
  - Will incur a surrender charge or be subject to the start of a new surrender period
  - Will lose existing contractual benefits
  - Will be subject to increased fees, investment advisory fees, or charges for riders and product enhancements
  - Will benefit from product enhancements and improvements
  - Has transacted another annuity exchange or replacement and, in particular, has had one within the preceding 36 months.

Insurers are required to review annuity applications for suitability and will not issue one unless they determine the recommendation is suitable. Annuity sales made in compliance with FINRA suitability requirements and supervised under FINRA rules satisfy the requirements of Florida’s suitability law.

In performing a suitability analysis, producers must collect information on a state approved form H1-1980 Annuity Suitability Questionnaire. This form incorporates the client's financial situation with the **12 points of suitability** information to help producers determine whether an annuity is a suitable purchase. In the case of a replacement, the form H1-1981 called Disclosure and Comparison Form must also be completed. Producers must submit both completed forms to the insurer with the application within ten (10) days of the sale, keep copies in their files, and provide copies to the client no later than the contract delivery date.

69B-162.011 Suitability and Disclosure in Annuity Investments — Forms Required.
(1) Forms Adopted.

(2) Application.
This rule applies exclusively to any recommendation to purchase or exchange an annuity contract as defined in subsection 627.4554(2), F.S., made to a consumer by an insurance agent or an insurer, which results in the purchase or exchange recommended.

(3) Duties of Insurers and Insurance Agents.
(a) Before executing a purchase or exchange of an annuity to a consumer, an insurance agent or an insurer, unless exempted by paragraph 627.4554(5)(i), F.S., and required by the Financial Industry Regulatory Authority to perform an alternative suitability analysis, must use form DFS-H1-1980, Annuity Suitability Questionnaire, incorporated in subsection (1) above, to obtain information in order to determine the suitability of the recommendation.

(b) In addition to obtaining the information required by paragraph (a), before executing a replacement or exchange of an annuity contract to a consumer, the insurance agent or insurer must also provide contract comparison information to the consumer utilizing form DFS-H1-1981, Disclosure and Comparison of Annuity Contracts, incorporated in subsection (1) above.

(c) The type face for all printed questions or requests for information that will be directly received or answered by the consumer, and all portions of the referenced forms relating to the disclosure requirements according to paragraphs (3)(a) and (b) above, must be of least 12-point type.

(d) Nothing in this rule shall prevent an insurer from adapting the forms adopted in subsection (1) for its use, upon written approval of any modifications by the Department. The Department shall approve an insurer’s modification to the forms provided:
   1. The forms still contain all of the same information as the Department forms referenced above;
   2. The type size requirement of paragraph (3)(c) above is met;
   3. Additional material added to the form does not obscure the information required, or rearrange the required information in such a way as to make it more difficult to find or understand;
   4. The revised form does not contain misrepresentations or misleading statements, and is not in any other way in violation of section 626.9541, F.S.

(e) Insurers are permitted to modify the form to use check-off boxes for indication of investment experience and risk tolerance, but shall not substitute check-off boxes for any other items on the form.

(f) The addition of an insurer’s name, contact information, or trademark; the addition of borders; or changes in font which do not alter type size, do not require prior written approval by the Department.

(g) Approval by the Department does not preclude disapproval by the Florida Office of Insurance Regulation according to any provision of the Florida Insurance Code, and rules adopted there under.

Rulemaking Authority 624.308(1), 627.4554(9) FS. Law Implemented 627.4554 FS. History—New 12-25-09, Amended 10-21-14.
DEPARTMENT OF FINANCIAL SERVICES
Division of Agent & Agency Services - Bureau of Investigation

ANNUITY SUITABILITY QUESTIONNAIRE

Owner: Last __________ First __________ Middle __________
Date of Birth _______ / _______ / _______ Age _______ Sex _______
Entity: __________________________
Tax Status __________________________ Relationship to Annuitant(s): __________________________
Form of Ownership: __________________________
Supporting documents (list): __________________________

Annual Income: __________________________
Source of Income: __________________________
Annual Household Income: __________________________
Existing Assets: __________________________
Existing Liquid Net Worth: __________________________

Do you currently own any annuities? Please list: __________________________

□ Yes □ No __________________________

Do you currently own life insurance? Please list: __________________________

□ Yes □ No __________________________

Does your income cover all your living expenses including medical? __________________________

□ Yes □ No __________________________

Do you expect changes to your living expenses? __________________________

□ Yes □ No __________________________

Do you anticipate changes in your out-of-pocket medical expenses? __________________________

□ Yes □ No __________________________

Is your income sufficient to cover future changes in your living and/or out-of-pocket medical expenses during the surrender charge period? __________________________

□ Yes □ No __________________________

Do you have an emergency fund for unexpected expenses? __________________________

□ Yes □ No __________________________

Why are you purchasing this annuity? __________________________

What are your financial objectives for this purchase? (Check all that apply)

□ Income □ Growth (long term) □ Safety of Principal and Income

□ Safety of Principal and Growth □ Pass assets to a beneficiary or beneficiaries at death

□ Other: __________________________

Owner’s Signature __________________________ Date Signed __________________________

DFS.H1-1960
Effective 10/21/2014

Rule 69B-162.011, F.A.C.
Describe your risk tolerance: (Check all that apply)

☐ Conservative  ☐ Moderately conservative  ☐ Moderate  ☐ Moderately aggressive
☐ Aggressive  ☐ Other: ________________________________

Comments: ________________________________

Describe your investment experience by type and length of time: ________________________________

What is the source of the funds for the purchase of the proposed annuity?

How many years from today will you need access to your funds without a penalty?

Will the proposed annuity replace any product? ☐ Yes  ☐ No
If yes, will you pay a penalty or other charge to obtain these funds? ☐ Yes  ☐ No
If yes, the amount of the charge or penalty $ ________________________________

Additional Information: ________________________________
Note: The following three sections to be completed by the agent, insurer, or Managing General Agent proposing purchase; each section requires a response; no section may be left blank or contain a response consisting of “None” or “N/A”.

Advantages of purchasing the proposed annuity:

Disadvantages of purchasing the proposed annuity:

The basis for my recommendation to purchase the proposed annuity or to replace or exchange your existing annuity (ies):

Agent’s Signature __________________________ Date Signed _____________

Note: No questions or response areas are to be left blank when offered to the Owner for signature. If any information requested is unavailable, not applicable or unknown, the insurance agent or insurer must indicate that.

ACKNOWLEDGEMENTS AND SIGNATURES

I understand that should I decline to provide the requested information or should I provide inaccurate information, I am limiting the protection afforded me by the Florida Statutes regarding the suitability of this purchase.

☐ I REFUSE to provide this information at this time.
☐ I have chosen to provide LIMITED information at this time.
☐ My annuity purchase IS NOT BASED on the recommendation of this agent or the insurer.
☐ My annuity purchase IS BASED on the recommendation of this agent or the insurer.

APPLICANT:

DO NOT SIGN THIS FORM IF ANY ITEM HAS BEEN LEFT BLANK, BEFORE CAREFULLY REVIEWING THE INFORMATION RECORDED, OR IF ANY OF THE INFORMATION RECORDED IS NOT TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE.

THE OWNER MAY SUBSTITUTE THEIR INITIALS FOR SIGNATURES ON ALL FORM PAGES WITH THE EXCEPTION OF THE SIGNATURES BELOW, WHICH ARE REQUIRED.

Owner’s Signature __________________________ Date Signed _____________
EXPLANATION OF TERMS

“Age” is the natural person’s attained age on the day the form is completed.

“Tax Status” is the owner’s Federal Income Tax filing status such as “single” or “married filing jointly”; if “Exempt,” so state.

“Form of Ownership” is the type of entity, other than a natural person, including a corporation, trust, partnership, limited liability company, or other business or not-for-profit entity.

“Supporting documents” are the documents that provide a basis for the relationship between the Proposed Annuitant, and the Owner as it may exist.

“Annual income” is income received during a calendar year, whether earned or unearned.

“Source of annual income” is the income-generating source, such as pension income, dividends, or earned income etc.

“Annual household income” is the combined annual income received by all household members each calendar year.

“Existing Assets” are financial assets including life insurance and annuities.

“Existing Liquid Net Worth” is applicable to those net assets that can readily be converted into their cash equivalent, without loss of principal after all surrender charges or other deductions have been taken.

“Financial Objectives” are the owner’s stated goals as described to the insurance agent or insurer. If no insurance agent is involved. These may include but are not limited to the following: (1) Income, (2) Growth (long term capital appreciation), (3) Safety of Principal and Income, (4) Safety of Principal and Growth, (5) To pass the investment to a beneficiary or beneficiaries at death.

“Risk Tolerance” means the degree of uncertainty that an investor can reasonably tolerate with regard to a negative change in his or her investments. Examples of risk tolerance levels may include the following: (1) Conservative (prefer little or no risk), (2) Moderately conservative (some risk, reduced safety of principal), (3) Moderate (average risk with potential losses and potentially higher returns), (4) Moderately aggressive (above average risk with potential losses, risk of principal and potentially higher returns), (5) Aggressive (willing to sustain losses or loss of principal in pursuit of higher returns).

“Source of the funds” to be used to purchase the proposed annuity means from where the funds will come to purchase the annuity, and may include but are not limited to; (1) An existing annuity or life insurance contract, (2) Liquid Assets, including but not limited to, cash in banks, maturing certificates of deposit, and money market accounts, (3) Personal Loans, (4) Equity Loans, (5) Mortgages, Reverse Mortgages, (6) Death Benefit Proceeds, (7) Funds received upon retirement from employment, including but not limited to, 401(k) accounts, pensions, and other tax-sheltered funds, (8) Equities, mutual funds, or bonds, (9) Proceeds from real estate transactions.

Owner’s Signature

Date Signed

DFS-H1.1980
Effective 10/21/2014

Page 4 of 4
Rule 69B-162.011, F.A.C.
## Disclosure and Comparison of Annuity Contracts

### Existing Annuity Contract

<table>
<thead>
<tr>
<th><strong>Annuitant(s):</strong></th>
<th><strong>Insurer:</strong></th>
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<tbody>
<tr>
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<tr>
<th><strong>Contract #:</strong></th>
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### Proposed Annuity Contract

<table>
<thead>
<tr>
<th><strong>Annuitant(s):</strong></th>
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<tr>
<th><strong>Insurer:</strong></th>
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<tr>
<th><strong>Application #:</strong></th>
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### Comparison Table

<table>
<thead>
<tr>
<th><strong>Contract Issue Date</strong></th>
<th><strong>EXISTING ANNUITY CONTRACT</strong></th>
<th><strong>REPLACEMENT ANNUITY</strong></th>
</tr>
</thead>
<tbody>
<tr>
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<td>Mo</td>
<td>Day</td>
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<tr>
<td><strong>Generic Contract Type</strong></td>
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<tr>
<td><strong>Marketing Name</strong></td>
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<tr>
<td><strong>Initial Premium</strong></td>
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<tr>
<td><strong>Source of Initial Premium</strong></td>
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<tr>
<td><strong>Qualified Contract?</strong></td>
<td></td>
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<tr>
<td><strong>Annuity Maturity Date</strong></td>
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<td></td>
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<tr>
<td><strong>Death Benefit Amount</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Change of Annuitant upon Death Available?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surrender Charge Period in Years</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>First Year Surrender Charge Percentage Rate</strong></td>
<td></td>
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<tr>
<td><strong>Surrender Charge Schedule for Remaining Years</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Free Withdrawals Available?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Free Withdrawal Percentage Rate</strong></td>
<td></td>
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<tr>
<td><strong>Potential tax penalty for surrender/sale/exchange/annuitization (Describe)</strong></td>
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<tr>
<td><strong>Investment/Insurance components (Describe)</strong></td>
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<tr>
<td><strong>Waiver of Surrender Charge Benefit or Similar Benefit?</strong></td>
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<tr>
<td><strong>Riders, Features/Cost (Describe)</strong></td>
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<tr>
<td><strong>Loss of Benefits or Enhancements if existing contract exchanged? (Describe)</strong></td>
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<tr>
<td><strong>Living Benefits (Describe)</strong></td>
<td><strong>EXISTING ANNUITY CONTRACT</strong></td>
<td><strong>REPLACEMENT ANNUITY</strong></td>
</tr>
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<td>-------------------------------</td>
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</tr>
</tbody>
</table>

| **Minimum Guaranteed Interest Rate** | % | % |
| **Limitations on interest returns (Describe)** |   |   |

| **Interest Rate Cap / Term** | / | / |
| **Participation Rate / Term** | / | / |
| **Indexing Method / Term** | / | / |
| **Other Fees (Describe)** |   |   |

| **Initial Bonus Percentage or Amount** |   |   |
| **Potential Loss of Bonus if Exchanged?** | Yes | No | Yes | No |
| **Limits and Exclusions for Bonuses that may be payable (Describe)** |   |   |

Comments and continuation from above:

____________________________________________________

____________________________________________________

____________________________________________________

____________________________________________________

Owner’s Signature: ___________________________ Date Signed: ___________________________
DISCLOSURE OF SURRENDER CHARGES IF EXISTING ANNUITY IS REPLACED OR EXCHANGED

EXISTING ANNUITY CONTRACT NO. _______________________________________

Annuity Total Value $ ___________ Annuity Surrender Value $ ___________

Surrender Charges Applicable at exchange $ ___________ ~ this is the estimated amount that will be deducted from the existing annuity’s total value if surrendered, replaced, or exchanged, with an anticipated surrender date of ______ / ______ / ______.

Have you surrendered or exchanged an annuity contract in the last 36 months? If yes, provide details: □ Yes □ No

____________________________________________________________________

ACKNOWLEDGEMENTS AND SIGNATURES

I acknowledge that I have provided the Applicant with a completed and signed copy of this form.

__________ ____________________________________
Agent’s Name (please print) Florida License No.

__________ ____________________________________
Agent’s Signature Date Signed

NOTE: NO QUESTIONS OR RESPONSE AREAS ARE TO BE LEFT BLANK WHEN OFFERED TO THE ANNUITANT AND/OR APPLICANT FOR SIGNATURE. IF ANY INFORMATION REQUESTED IS UNAVAILABLE, NOT APPLICABLE OR UNKNOWN, THE INSURANCE AGENT OR INSURER MUST INDICATE THAT.

THE OWNER MAY SUBSTITUTE THEIR INITIALS FOR SIGNATURES ON ALL FORM PAGES WITH THE EXCEPTION OF THE SIGNATURES BELOW, WHICH ARE REQUIRED.

APPLICANT: DO NOT SIGN THIS FORM IF:
1. ANY ITEM HAS BEEN LEFT BLANK;
2. WITHOUT CAREFULLY REVIEWING THE INFORMATIONRecorded; OR
3. IF ANY OF THE INFORMATIONRecorded IS NOT TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE.

__________ ____________________________________
Owner’s Name (please print)

__________ ____________________________________
Owner’s Signature Date Signed

DFS-H1-1981
Rev. 10-01-2013

Page 3 of 5
Adopted in Rule 69B-162.011, F.A.C.
EXPLANATION OF TERMS

“Generic Contract Type” is the generic name of the annuity contract form as approved by the Florida Office of Insurance Regulation. Examples of generic annuity contract names are Flexible Premium Equity Indexed Annuity (FPEIDA), Single Premium Immediate Annuity (SPIA), Flexible Premium Variable Deferred Annuity (FPVDA), and Single Premium Deferred Annuity (SPDA).

“Marketing Name” is the name adopted by the insurer to identify the contract form.

“Qualified Contract” means a product used to fund any type of pension plan approved by the Internal Revenue Service.

“Annuity Maturity Date” is the final date of termination of the contract at which time the proceeds of the contract must be paid out.

“Surrender Charge” is the amount deducted from annuity contract values upon surrender of an annuity, or for withdrawals exceeding any free withdrawal provision of the contract, regardless how this charge is titled in the policy, e.g., deferred sales charge.

“Surrender Charge Period” is the number of annuity contract years a surrender charge may be applicable.

“Initial Surrender Charge Percentage Rate” is the original percentage rate that is deducted from annuity values at the inception of the existing annuity contract, or that will be deducted from the recommended replacement contract at its inception if purchased.

“Surrender Charge Percentage Schedule for Remaining Years” the percentage rate that would be deducted from the existing annuity contract if surrendered, or for any withdrawals exceeding the “free withdrawal” limit.

“Minimum Guaranteed Interest Rate” is the minimum interest rate payable under the annuity contract as guaranteed by the insurer in the annuity contract.

“Initial Bonus Percentage or Amount” is a bonus paid by the insurer, generally, at inception of the annuity contract, and may be expressed as a percentage of the initial premium or other amount, or a dollar amount, and must be stated in the annuity contract.

“Potential Loss of Bonus if Exchanged” refers to whether any bonus would be lost if the annuity contract was exchanged or terminated for any reason.

“Interest Rate Cap” this is the maximum rate of interest the annuity will earn.

Owner’s Signature

Date Signed
EXPLANATION OF TERMS

(CONTINUED)

“Participation Rate” the participation rate decides how much of the increase in the index will be used to calculate index—linked interest.

“Indexing Method” means the approach used to measure the amount of change, if any, in the index and includes annual reset (ratcheting), high-water mark and point-to-point. The index term is the period over which index-linked interest is calculated. “Market Value Adjustment” is the increase or decrease in the surrender value of the contract that is adjusted to reflect market fluctuations.

“Administrative Fees or Margins” are charges that amount to the difference between the percentage gain in the index and the actual amount credited to the annuity contract.

“Asset Fees” are the fees the insurer charges that are a percentage of the value of the annuity contract.

“Death Benefit Amount” is the net amount that would be paid to the annuitant’s designated beneficiary or beneficiaries of an existing annuity, or the death benefit that the proposed replacement policy would pay as of the contract issue date.

“Free Withdrawals” are the withdrawals that may be taken from an annuity’s values that are not subject to surrender or other charges and are a provision of the annuity contract.

“Annual Free Withdrawal Percentage Rate” is the percentage of available funds that may be withdrawn from an annuity contract, generally on an annual basis and is stated in the annuity contract.

“Change of Annuitant upon Death” is a provision that allows another person to become the annuitant upon the death of the original annuitant allowing the contract to remain in force.

“Waiver of Surrender Charge Benefit or Similar Benefit or Provision” is a benefit that is built into individual annuity contracts or added by rider, endorsement or amendment. The benefits are triggered by a qualifying event associated with either the annuitant or owner, as specified in the contract.
D. Unfair Methods of competition and unfair or deceptive acts

There are strict prohibitions against distributing an advertisements or announcement containing untrue, deceptive, or misleading statement regarding the producer, insurer, or insurance product. In Florida agents and insurers that use advertisements that are untrue, deceptive or misleading will be guilty of an unfair method of competition and unfair or deceptive act.

According to F.S. § 626.9541(1)(a)(b), the following are unfair methods of competition and unfair or deceptive acts or practices:

- **Misrepresenting and false advertising of insurance policies.** Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison, altered after being issued, which:
  - Misrepresenting the benefits, advantages, conditions, or terms of any insurance policy.
  - Misrepresenting the dividends or share of the surplus to be received on any insurance policy.
  - Making false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy.
  - Misleading, or is a misrepresentation, as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates.
  - Using a name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof.
  - Misrepresenting for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.
  - Misrepresenting for the purpose of affecting a pledge or assignment of, or affecting a loan against any insurance policy.
  - Misrepresenting any insurance policy as being shares of stock or misrepresents ownership interest in the company.
  - Using an advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the insurance sales activities of any person or stands behind any person’s credit or that any person, the state, or the Federal Government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person.

- **Using false information and advertising.** Knowingly making, publishing, disseminating, circulating, or placing, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public:
  - In a newspaper, magazine, or other publication,
  - In the form of a notice, circular, pamphlet, letter, or poster,
  - Over any radio or television station, or
  - In any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, which is untrue, deceptive, or misleading.

There are a number of state insurance laws that cover the area of marketing and unfair insurance trade practices. These laws are made up of the model regulations passed by the National Association of Insurance Commissioners.
back in 1940, known as “The Unfair Marketing Practices Model Regulations,” since that time the NAIC has made several amendments and the Model Regulation with all of its amendments has become part of every state’s insurance code.

In Florida, you can find this regulation under F.S. 626.9541 and 626.9521, it is known as “Florida’s Unfair Methods of Competition and Unfair or Deceptive Acts.”

Florida Unfair Trade Practices - The state of Florida’s Unfair Insurance Trade Practices Act can be found in the Florida Statutes, Title XXXVII, Chapter 626.9521. Recently, with the passage of the “Seibel Act”, several new amendments to the Unfair Trade Practices Act were added.

Misrepresentation and False Advertising of Life Insurance - According to F.S. § 626.9541(1(a), misrepresentation is simply a false statement of fact; that is a lie. For many insurance producers, the biggest market conduct danger they may face is making a misrepresentation during a sales presentation. Sometimes, it is the result of over-enthusiasm of selling the benefits of a policy too strongly. It may also be the result of a willingness to stretch the advantages of a product and sidestep the disadvantages. While on the other hand, providing vague or elusive responses is just as serious a form of misrepresentation as is deliberately lying about a policy’s features and benefits or expected performance. Two forms of misrepresentation are twisting and churning.

The Florida Code of Ethics addresses four main activities:

- Misrepresentation
- Twisting
- Rebating
- Defamation

Misrepresentation and False Advertising of Life Insurance - According to F.S. § 626.9541(1(a), misrepresentation is simply a false statement of fact; that is a lie. For many insurance producers, the biggest market conduct danger they may face is making a misrepresentation during a sales presentation. Sometimes, it is the result of over-enthusiasm of “selling” the benefits of a policy too strongly. It may also be the result of a willingness to stretch the advantages of a product and sidestep the disadvantages. While on the other hand, providing vague or elusive responses is just as serious a form of misrepresentation as is deliberately lying about a policy’s features and benefits or expected performance. Two forms of misrepresentation are “twisting” and “churning”.

Twisting - According to § 626.9541(1), F.S., Rule 69B-215.215 F.A.C, twisting is knowingly making any misleading representations or incomplete or fraudulent comparisons or fraudulent material omissions of or with respect to any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer. It is both unethical and illegal.

The Florida Code of Ethics prohibits twisting, which involves making a misrepresentation or fraudulent comparison to induce a policyholder to lapse, forfeit, surrender, or terminate an insurance policy and take out a policy with another insurer. Of course, it is not illegal for agents to encourage clients to replace an existing policy with another if it is in the clients’ best interests to do so. However, inducing clients to change their insurance coverage based on misrepresentations or deception is unlawful.

Churning - According to § 626.9541(aa), F.S., “Churning” is the practice whereby policy values in an existing life insurance policy or annuity contract, including, but not limited to, cash, loan values, or dividend values, and in any
riders to that policy or contract, are directly or indirectly used to purchase another insurance policy or contract with that same insurer for the purpose of earning additional premiums, fees, commissions, or other compensation under the following conditions:

- Without an objectively reasonable basis for believing that the replacement or extraction will result in an actual and demonstrable benefit to the policyholder;
- In a fashion that is fraudulent, deceptive, or otherwise misleading or that involves a deceptive omission;
- When the applicant is not informed that the policy values including cash values, dividends, and other assets of the existing policy or contract will be reduced, forfeited, or used in the purchase of the replacing or additional policy or contract if this is the case, or
- Without informing the applicant that the replacing or additional policy or contract will not be a paid-up policy or that additional premiums will be due if this is the case.

This section also requires that all insurers must adopt written procedures to avoid churning policies or contracts that it has issued. Failure to do so will be an unfair method of competition and an unfair or deceptive act or practice.

In addition, the F.S. § 626.9541(1)(aa) was amended to prohibit specifically “indirect churning.” This occurs when a policy is surrendered, and the resulting funds are used to purchase both an immediate and a deferred annuity, thus creating a double commission for the agent.

**FRAUDULENT SIGNATURES** - According to F.S. § 626.9541 (1)(ee), this section adds a prohibited practice of submitting to an insurer on behalf of a consumer a document bearing a false signature.

| Case: An investigation of a life, health, and variable annuity agent revealed that she submitted two life insurance applications on individuals whom she had never met with prior to or during the sale to earn commissions. According to the documents provided by a company SIU investigator, the agent submitted the two applications with fraudulent applicant signatures, incorrect health information, and she also provided saliva samples that were not from the named insureds. |
|**Disposition:** License suspended for 12 months. |

*Insurance Insights, Volume 3, No. 5 - May 2014*

| Case: A life and health agent received two group applications from another agent and then submitted the two group applications as her own to an insurer. The agent forged the business owner’s signatures on acceptance forms and forged each employee applicant’s signature on the individual applications. In the agent signature area, the agent attested to “personally” contacting and verifying the information for the two groups. |
|**Disposition:** Fined $6,000 and placed on probation for two years. The insurer cancelled their contract with the agent. |

*Insurance Insights, Volume 3, No. 2 - February 2014*

| Case: An investigation of a life and health agent revealed a struggle to complete the sale of an annuity. The agent decided to move forward without consulting his client. The agent proceeded to forge the consumer’s name to a form that transferred nearly $10,000 from her life policy to the annuity. The Department successfully intervened and reversed the funds transfer for the consumer and nullified the transaction. |
|**Disposition:** License suspended for six months. |
Case: An insurance carrier filed a complaint with the Department stating that they discovered a life agent who had allegedly forged client signatures on applications for insurance as well as embellished the policy and loan provisions for a life insurance customer in order to entice them to purchase the policy. During the investigation, it was revealed that the agent was signing in place of clients and had 65 life insurance policies in a drawer that had never been delivered to his clients. According to the agent, he felt that the cost of mailing the policies to his clients was too expensive and he did not have time to personally deliver them.

Disposition: License revoked. Also, he is currently paying back over $67,000 in restitution to the company to reimburse their costs in remedying the harm caused by him in falsifying the policy and loan provisions.

Unlawful Use of Designations - According to F.S. § 626.9541(1)(ff), agents are prohibited from using designations or titles that falsely imply they have special financial knowledge or training. Unlawful use of designations and misrepresentation of agent qualifications include the following:

- A licensee may not, in any sales presentation or solicitation for insurance, use a designation or title in such a way as to falsely imply that the licensee:
  - Possesses special financial knowledge or has obtained specialized financial training; or
  - Is certified or qualified to provide specialized financial advice to senior citizens.
- A licensee may not use terms such as “financial advisor” in such a way as to falsely imply that the licensee is licensed or qualified to discuss, sell, or recommend financial products other than insurance products.
- A licensee may not, in any sales presentation or solicitation for insurance, falsely imply that he or she is qualified to discuss, recommend, or sell securities or other investment products in addition to insurance products.
- A licensee who also holds a designation as a Certified Financial Planner (CFP), chartered life underwriter (CLU), chartered financial consultant (ChFC), life underwriter training council fellow (LUTC), or the appropriate license to sell securities from the Financial Industry Regulatory Authority (FINRA) may inform the customer of those licenses or designations and make recommendations in accordance with those licenses or designations, and in so doing does not violate this paragraph.

Consumer Protections - According to F.S. § 626.025, to transact insurance, agents must comply with consumer protection laws, including the following, as applicable:

- The prohibition against the designation of a life insurance agent or his or her family member as the beneficiary of life insurance policy sold to an individual other than a family member under F.S. § 626.798.

REBATING

Splitting a commission or paying a client for his or her business is considered "rebating." Rebating occurs if the buyer of an insurance policy receives any part of the insurance producer's commission or anything else of significant value as an inducement to purchase the insurance product being sold by the insurance producer. Rebating is not illegal in the state of Florida:

- Florida (Rules specific to the allowance of rebating are found in the 2012 Florida Statues, Title XXXVII, Section 626.572).
However, most insurers forbid their insurance producers to rebate even in jurisdictions where it is legal. It is acceptable to provide gifts of nominal value (pens, calendars, coffee mugs, etc.) to prospects and clients when those gifts are given regardless of whether or not you make a sale. If you provide a nominal gift, you must provide it to everyone you approach.

Under the Florida Code of Ethics, rebating is unethical and, as we will discuss later, is permitted in the state of Florida only in very limited circumstances and agents who are permitted to rebate must follow strict requirements. Insurers and agents generally cannot pay or offer to pay anything of value (up to $100 in aggregate) for someone to buy insurance, including a rebate of the premium, dividends, or stocks and securities. The also cannot pay or offer to pay anything of value that is not specified in the insurance contract, such as agreeing to give customers tickets or gift cards if they purchase insurance.

Defamation

Defamation is defined as publishing or circulating a false, deceptive, or misleading statement about or a statement that is maliciously critical of or derogatory to the financial condition of an insurer, when such a statement is designed to injure anyone in the insurance business. Defamation can include both written and spoken (slander) statements about a third party in the insurance industry.

Penalties

Following an investigation and a hearing, if the DFS or OIR finds that any agent or insurer is engaged in any unfair marketing practices or unfair claims practice, the Commissioner may issue a cease and desist order prohibiting the agent or insurer from continuing the practice. Failure to comply with the cease and desist order can result in a substantial fine (usually $10,000). In addition, fines and loss of license may also be imposed for any agent or insurer guilty of violating the Unfair Marketing & Trade Practices Act.

The DFS may also issue a consent order, a disciplinary action in which the party at fault (the agent or insurer) agrees to discontinue a particular practice (usually an unfair marketing practice or claims practice), through a written agreement with the DFS. Usually the individual denies the allegations but consents to the action taken by the department. Consent orders (also known as consent decrees) may or may not involve a fine.

Case: The Department received notification that an agent had made material misstatements on his application for licensure in 2003 and 2011; he did not divulge action taken against him by the Department of Banking and Finance in 2002. Furthermore, he did not inform the Department of Financial Services within 30 days of the enforcement action. Since this was not discovered until 2019, the agent determined that it was in his best interests to pursue a Consent Order.

Disposition: By consent order, the agent was fined $2,500, and agreed to adhere to rules about disclosures and notification.

Insurance Insights, Volume 8, No. 6 - Dec 2019

According to § 626.9521(2), F.S., unfair methods of competition and unfair or deceptive acts or practices prohibited; Penalties, any person who violates any provision of this part is subject to a fine in an amount not greater than $2,500 for each non-willful violation

According to F. S. § 626.9521(3)(b), if a person violates the offense of either “twisting” or “churning”, the person commits a misdemeanor of the first degree, punishable as provided in F.S. § 775.082, and an administrative fine
not greater than $5,000 for each non-willful violation or an administrative fine, not greater than $75,000 for each willful violation. To impose an administrative fine for a willful violation under this section, the practice of “twisting” or “churning” must involve fraudulent conduct.

According to F. S. § 626.9541(1)(ee), by willfully submitting fraudulent signatures on an application or policy-related document, the person commits a felony of the third degree, punishable as provided in F.S. § 775.082, and an administrative fine not greater than $5,000 for each non-willful violation or an administrative fine not greater than $75,000 for each willful violation. Fines under this subsection may not exceed an aggregate amount of $100,000 for all non-willful violations arising out of the same action, or an aggregate amount of $500,000 for all willful violations arising out of the same action. The fines may be imposed, in addition to any other applicable.

According to F.S. § 626.9521(3)(c), administrative fines under this subsection may not exceed an aggregate amount of $50,000 for all non-willful violations arising out of the same action or an aggregate amount of $250,000 for all willful violations arising out of the same action.

The DFS has also developed a marketing campaign, “Verify before You Buy,” Remember the saying if it is too good to be true, it probably is.

To check on the license status of a company, agents and consumers should visit http://www.myfloridacfo.com/Division/Consumers/PurchasingInsurance/VerifyBeforeYouBuy.htm, or call the DFS Helpline at 1-800-342-2762.

INSURANCE FRAUD

**Case:** The Department received notification that a nonresident life agent had an action filed against him by the Financial Industry Regulatory Authority (FINRA) wherein the agent was suspended from association with any FINRA member for five months and fined $30,000. The action was taken based on the agent’s participation in selling unregistered securities in the form of life settlements. According to department records the agent had also not licensed his agency. During the investigation it was determined that the subject’s business, mailing and email addresses were invalid. The agent also failed to inform the Department of this action within 30 days of the final disposition.

**Disposition:** License surrendered and cannot re-apply for two years.

*Insurance Insights, Volume 3, No. 6 - June 2014*

**Case:** A life and health agent submitted multiple fraudulent applications in connection to a phony group, using fake clients, and was advanced more than $16,000 in commissions. The company was unable to verify the authenticity of the information on the applications due to invalid information on them. Each application also had phony bank information. The phony group used the name of a corporation that the agent had formed and was paid for with a check from the phony group. The agent bypassed his up-line agent who always reviewed the applications before forwarding them on to the insurer.

**Disposition:** License suspended for six months; fined $500; and his authority to be a course provider or school official was revoked.

*Insurance Insights, Volume 3, No. 7 - August 2014*

**Case:** The Department received notification from an insurance carrier that it had terminated a life & health agent for cause. The termination stemmed from allegations that the agent represented himself as various applicants
during verification calls on electronic applications, which were submitted by him. He also posed as applicants to move their policy effective dates and request cancellations as though he was the insured. The investigation showed that these persons did not exist.

A former employee of the agent contacted the carrier and questioned why her bank account had been drafted when she didn’t even have a policy with them. Further, the unauthorized draft was done with the same bank account that the agent used to direct deposit her pay when she worked for him. It was this call that prompted the insurance carrier to perform its internal investigation.

It was determined that there were six fraudulent applications placed using the phone or work phone of the agent. On three applications, he used the banking information of previous applicants. The policies that were mailed to proposed insureds were returned by the post office as undeliverable.

Disposition: License revoked.

One of the most serious problems facing the insurance industry today is insurance fraud. It is estimated that insurance fraud costs the United States $80 billion dollars or more a year, which are ultimately passed down to consumers. The Coalition Against Insurance Fraud (CAIF) estimates this fraud to cost approximately $950 per family.

In Florida, the Division of Insurance Fraud, since it was first established in 1976, enforces the state’s criminal laws with respect to insurance transactions. Investigators are certified law enforcement officers with the authority to bear arms and make arrests. The division serves and safeguards the public and businesses in Florida against acts of insurance fraud and the resulting impact of those crimes on taxpayers. According to its most recent report (FY 2012/2013), received 15,447 suspected fraud referrals, made 1,571 arrests, had 1,079 convictions, requested over $59 million in restitution, and received over $112 million in court ordered restitution. To view the report, go to: http://www.myfloridacfo.com/Division/Fraud/Resources/documents/20122013_AnnualReport.pdf

According to F.S. § 817.234, a person commits insurance fraud if he or she does the following:

- Makes a statement when submitting a claim that contains false, incomplete, or misleading information;
- Helps another person make a statement in connection with a claim that contains false, incomplete, or misleading information; or
- Knowingly submits an insurance application containing false, incomplete, or misleading information or conceals information that is material to the application.

To discourage fraud, all claims and application forms must contain the following statement:

“Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.”

If a person is found guilty of insurance fraud, the insurer may recover compensatory damages as well as its investigation and litigation expenses, including attorney’s fees, from such person.

SPECIFIC FLORIDA LAWS AND RULES

Like all other states, Florida regulations prohibit deceptive sales practices. Only policies offered by approved (authorized) insurers may be offered to residents of the state. Florida Rule 69B-230 requires agents who are
aware of unauthorized insurers operating in the state to notify the Department of Financial Services of such unauthorized activity.

In addition, there are many state regulations agents must be aware of to conduct an ethical insurance practice:

**Misrepresentation**

69B-215.230 Misrepresentations. (1) Misrepresentations are declared to be unethical. No person shall make, issue, circulate, or cause to be made, issued, or circulated, any estimate, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or make any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or make any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or use any name or title of any policy or class of policies misrepresenting the true nature thereof.

(2) No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, any advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

According to the Florida Code of Ethics, it is unlawful for agents to make false or misleading statements about dividends paid on a policy or on similar policies, or to make false or misleading statements about the financial condition of an insurer.

It is also unlawful for agents to publish or circulate a false, deceptive, or misleading statement about the insurance business or about anyone involved in the insurance business. More specifically, this means that advertisements may not:

- Conceal the true identity of the insurer;
- Mislead the public as to the true role of the agent;
- Misrepresent the product as something other than insurance; or
- Provide incorrect information regarding a product’s features and benefits.

Certainly in many cases, an agent may unintentionally make a misrepresentation or fraudulent comparison and may believe he or she is being truthful. However, an agent’s ignorance of the facts or the law is not a defense against liability for misrepresentation. To summarize, agents are responsible for the statements they make because they have an ethical duty to understand the products they sell and to present the policies truthfully.

**Defamation** - According to statute 626.9541(1)(c) Defamation is defined as publishing or circulating a false, deceptive, or misleading statement about—or a statement that is maliciously critical of or derogatory to—the financial condition of an insurer, when such a statement is designed to injure anyone in the insurance business. Defamation can include both written and/or spoken statements about a third party in the insurance industry.

**Defamation** is defined under Florida regulations as: "Knowingly making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating or circulating of, any oral or written statement, or pamphlet, circular, article or literature which is false or maliciously critical of or
derogatory to any person and which is calculated to injure such person." Defamation is a tort that includes both libel (written) and slander (spoken) of a person.

Use of Professional Designations

The Florida Code of Ethics regulates the use of certifications and professional designations when marketing, soliciting, and selling insurance to protect consumers from dishonest, deceptive, misleading, and fraudulent trade practices.

Agents doing business in the state of Florida can use designations only from an organization that maintains standards for assuring that its certificate holders (certificants) are competent on specific subject areas. In addition, agents cannot use professional designations if the following occurs:

- Designations they have not actually earned or are ineligible to use
- Designations which are nonexistent or self-conferred
- Designations that indicate or imply that the person has advanced training and knowledge

Penalties

If an agent in the state of Florida is found not to follow the Florida Code of Ethics his or her license may be suspended or revoked.

Policyholders’ Bill of Rights

According to F.S § 626.9641, the principles expressed in the following statements serve as standards to be followed by the department, commission, and office in exercising their powers and duties, in exercising administrative discretion, in dispensing administrative interpretations of the law, and in adopting rules:

- Policyholders have the right to competitive pricing practices and marketing methods that enable them to determine the best value among comparable policies.
- Policyholders have the right to obtain comprehensive coverage.
- Policyholders have the right to insurance advertising and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy.
- Policyholders have the right to an insurance company that is financially stable.
- Policyholders have the right to be serviced by a competent, honest insurance agent or broker.
- Policyholders have the right to a readable policy.
- Policyholders have the right to an insurance company that provides an economic delivery of coverage and that tries to prevent losses.
- Policyholders have the right to a balanced and positive regulation by the department, commission, and office.

This section will not be construed as creating a civil cause of action by any individual policyholder against any individual insurer.

Agents Ethics

The Law of Agency

This legal concept applies when someone (the agent) acts on another's (the principal's) behalf. This concept applies to a wide range of everyday situations - especially in the business world. For example, trusts and corporation (non-human legal entities) can only act through human intermediaries such as trustees, corporate
officers or employees. Insurance companies rely on an outside sales force to market their products, so the law of agency - and the salesperson’s contract with represented insurers - determines whether the individual is, in fact, an "agent" of the company.

The question sometimes arises: "To what extent is the principal bound by the agent's actions?" Only authorized acts of the agent can bind the company. So, the answer to that question depends, to a large extent, on the authority the principal confers on the agent. The law of agency recognizes three types of authority that may be given to agents:

- Express authority
- Implied authority
- Apparent authority

**Express Authority**

Express authority is conferred by a contract. Express authority is given to the agent through his or her contract with the insurer and any amendments made by the company to that contract. The contract explicitly announces the detailed grant of authority to the agent - and outlines his or her duties. Clearly, if the agent does only what he or she is given express authority to do, those actions would bind the company. As a result of this specificity, few compliance problems arise out of express authority.

**Implied Authority**

Unlike express authority, which is granted via a contract, implied authority comes from the powers that the company customarily gives its agents. For example, an insurer may give an agent the express authority to solicit applications for life insurance on its behalf; by doing so, it also gave the agent the implied authority to telephone prospects on its behalf to arrange sales appointments. Implied authority arises when it:

- is intended to be given by the insurer,
- usually relates to the general customs of the business,
- is not contractually provided, and
- is not specifically delineated.

Implied authority can lead to significant liability for insurers, especially if the company knowingly or negligently permitted its agents to engage in unethical sales practices. By the insurer’s failure to stop the agents’ unethical sales practices, a plaintiff could maintain that the company gave the agents implied authority to act in that fashion. To the extent that the insurer authorized that conduct - in this case through implied authority - it is responsible for it just as though it had specified that activity in the agent contract. If the insurer is deemed to have conferred that implied authority, the company could be held liable for any damages resulting from those acts. Implied authority has provided the legal basis for some of the successfully - maintained lawsuits alleging unethical marketing practices.

Insurers, in order to limit their liability, generally provide considerable direction to their field force as to permitted sales practices and advertising. Although implied authority creates many of the insurer’s liability concerns, the type of authority that causes most of the compliance problems is the last type: apparent authority.

**Apparent Authority**

The most troublesome level of authority, from the insurer’s perspective, is apparent authority. This is authority that a third party, such as a prospective client, can reasonably assume to be given to the agent by the principal. Apparent authority:
• is not provided by contract,
• is not intended by the insurer, but
• appears to the client to be given to the agent based upon the agent’s believable statements.

For example, an agent has a rate book and other internal literature from a major insurer and the agent holds himself out to be appointed by the insurer, even though he is not. A prospective client sees this literature and assumes the agent does indeed represent the company. The company can be held liable for the actions of the agent under the guise of apparent authority. Not surprisingly, apparent authority causes a majority of the liability for life insurers.

Even if the agent has none of those three types of authority, it is still possible for an insurer to be liable for the agent’s acts. That outcome may result from the insurer’s ratification of the agent’s acts.

**Ratification**

Insurers can, by their actions, confirm or approve of an agent's actions. This confirmation, known as "ratification", can bind the principal (the insurer) to the agent's actions if:

• the agent represented himself as an agent acting on behalf of the insurer;
• the customer believed the agent's representations;
• the insurer subsequently validates the agent's actions by ratifying them in some fashion; and
• the insurer ratifies the entire agent transaction.

It should be clear that agent actions may create both personal liability and insurer liability. It is principally the mitigation of that insurer liability that has caused much of the current emphasis that insurance companies have placed on compliance. Despite the fairly clear concepts that may result in liability, the issue of liability is anything but straightforward. In fact, there are a number of other elements that affect liability.

Insurance agents doing business in the state of Florida are bound by the Code of Ethics, which describes certain activities as unlawful in the insurance business. Agents are also encouraged to follow industry Codes of Ethics, which impose general ethical duties when working with clients and others in the profession. Ethical codes recognize that agents occupy positions of confidence and public trust, and must maintain high ethical standards at all times when interacting with clients.

In addition to the specific practices prohibited by these codes, insurance agents must also keep in mind the other general ethical practices, such as:

• Conducting business with clients, prospects, and other industry professionals according to high standards of honesty and fairness;
• Efficiently handling business, including complaints and disputes;
• Providing informed and client-focused service; and
• Engaging in fair competition and trade practices.

**Agents Responsibilities to Clients**

Insurance agents may owe a fiduciary duty to both to the companies they represent and to the insurance buying public. A fiduciary is a person in a position of financial trust. Attorneys, accountants, trust officers, pension plan trustees, stockbrokers and insurance agents are all considered fiduciaries. Agents who make recommendations to clients have an obligation to be knowledgeable about the features and provisions of the products they sell, as well as the prudent use of these products. Agents also must take the time to become acquainted with the client’s
financial needs, situation and objectives. Agents collect premiums on behalf of the insurers they represent, so they also have a fiduciary duty to submit those monies to the insurer promptly.

Insurance agents and brokers voluntarily accept this fiduciary responsibility and implicitly agree to carry out that duty in good faith. That has been interpreted by the courts to mean that fiduciaries must act reasonably to avoid negligence and to not favor anyone else's interest (including their own) over that of their clients or the companies that appointed them. Fiduciaries owe their principals (the person they represent):

- **Utmost Care** — one standard applied to fiduciaries is the "prudent man rule", which states that the fiduciary should behave as a "prudent person" would under the same circumstances. This can be a very vague standard, but it is one that courts have relied on over the years. Professionals are usually held to a higher standard of conduct — to exercise "utmost care". This higher standard is warranted because professionals are assumed to be more knowledgeable and experienced than an ordinary prudent person. One can argue that clients seek out and are willing to pay for professional advice precisely because of the added knowledge and experience the professional brings to the decision-making process - and therefore should be held to that higher standard.

- **Integrity** — this applies to the fiduciary's soundness of moral principle and character: the agent must act with fidelity to the principal's interest and with complete honesty.

- **Honesty and Duty of Full Disclosure** — of all material facts, either known, within the knowledge of or reasonably discoverable by the agent which could influence in any way the principal's decisions, actions or willingness to enter into a transaction.

- **Loyalty** — An obligation to refrain from acquiring any interest adverse to that of a principal without full and complete disclosure of all material facts and obtaining the principal's in-formed consent. This precludes the agent from personally benefiting from secret profits, competing with the principal or obtaining an advantage from the agency for personal benefit of any kind.

- **Duty of Good Faith** — includes total truthfulness, absolute integrity and total fidelity to the principal's interest. The duty of good faith prohibits taking advantage of the principal through the slightest misrepresentation, concealment, threat or adverse pressure of any kind.

In the case of conflicting interests, the agent must disclose the "dual agency" (acting for two parties at the same time) or risk being accused of fraud from either or both principals.

Most brokers are compensated by commissions. This, in itself, creates a difficulty since there is an inherent conflict of interest. It is common knowledge to most insurance purchasers that agents and brokers earn a sales commission, which may mitigate the conflict somewhat.

Florida courts addressed this commonly held knowledge in the case of **Beardmore v. Abbott** — ruling that a broker does have a fiduciary responsibility to his clients, but the broker's failure to disclose the full amount of his commission does not breach that duty. In this case, the client did not inquire as to the size of the commission at the time of the purchase, and broker did not volunteer the information. If the client had asked that question, presumably the courts would have ruled that the broker must honestly disclose that information as a matter of fiduciary trust. It should be noted that the client was very familiar with the insurance market, and knew that the broker would receive a commission — it was disclosure of the exact amount that was the crux in this case. Agents should, at least, make clients aware that they may receive a commission as part of an insurance/annuity transaction.

The fiduciary duty of insurance brokers was also addressed in another case: **Moss v Appel**. In this case, a broker helped a small business set up a pension funded with an annuity contract, and the broker was also hired to handle administrative paperwork for the pension plan. The broker received notice from the annuity company that it was
in seeking additional capital to remain in business, but he did not alert the clients to that notice. The annuity company later became insolvent. The courts ruled that the broker owed a fiduciary responsibility to his clients based on the sale of the annuity and the ongoing consulting/administrative contract. As the court noted, "It is undisputed that [the broker] was acting as an insurance broker, not an insurance agent employed by a particular company, when he sold the plaintiffs the annuity."

Presumably that distinction means that the broker should have placed the client's interests above any duty he may have felt to keep the contract in force with the troubled annuity company (even if it was the company that compensated him for the sale). In this case, there was a contract with the clients to administer the plan. The court did not indicate how that continuing relationship affected its ruling — or for how long after the annuity sale a broker (in the absence of a continuing relationship) owes that duty to his clients. These cases illustrate some of the problems that can arise for insurance brokers. As noted earlier, annuities are more likely to be "shopped around", which increases the likelihood that the sales person will be viewed as a broker, and not as an agent.

**Churning** — According to statutes 626.9541(1)(aa) and Rule 69B-151 Part III: If a company "replaces" its coverage with another policy, the agent must disclose this to the policyholder on Form OIR-B2-1180. In the past, some insurers induced existing clients - using misrepresentations - to let existing coverage lapse or reduce benefits and sell those clients another policy (Company A replaces Company A's coverage).

The Florida Code of Ethics prohibits twisting or churning, which involves making a misrepresentation or fraudulent comparison to induce a policyholder to lapse, forfeit, surrender, or terminate an insurance policy and take out a new policy.

Of course, it is not illegal or unethical for agents to encourage clients to replace an existing policy with another as long as it is in the clients’ best interests to do so. However, inducing clients to change their insurance coverage based on misrepresentations or deception is unlawful.

**Churning** - According to 626.9541(aa), F.S., Churning is the practice whereby policy values in an existing life insurance policy or annuity contract, including, but not limited to, cash, loan values, or dividend values, and in any riders to that policy or contract, are directly or indirectly used to purchase another insurance policy or contract with that same insurer for the purpose of earning additional premiums, fees, commissions, or other compensation under the following conditions; Without an objectively reasonable basis for believing that the replacement or extraction will result in an actual and demonstrable benefit to the policyholder; In a fashion that is fraudulent, deceptive, or otherwise misleading or that involves a deceptive omission; When the applicant is not informed that the policy values including cash values, dividends, and other assets of the existing policy or contract will be reduced, forfeited, or used in the purchase of the replacing or additional policy or contract if this is the case, or Without informing the applicant that the replacing or additional policy or contract will not be a paid-up policy or that additional premiums will be due if this is the case. This section also requires that all insurers must adopt written procedures to avoid churning policies or contracts that it has issued. Failure to do so will be an unfair method of competition and an unfair or deceptive act or practice. In addition, the F.S. 626.9541(1)(aa) was amended to prohibit specifically indirect churning. This occurs when a policy is surrendered, and the resulting funds are used to purchase both an immediate and a deferred annuity, thus creating a double commission for the agent.

**Fraudulent Signatures** - According to F.S. 626.9541 (1)(ee), this section adds a prohibited practice of submitting to an insurer on behalf of a consumer a document bearing a false signature.
Twisting - According to 626.9541(l), F.S., Rule 69B-215.215 F.A.C, twisting is knowingly making any misleading representations or incomplete or fraudulent comparisons or fraudulent material omissions of or with respect to any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer. It is both unethical and illegal. Generally, twisting implies the deceptive replacement of one annuity product for another from the same insurer. e.g., Company B replaces Company A’s policy.

Rebating – According to 69B-215.220 Rebating. Under the Florida Code of Ethics, rebating is unethical and is permitted in the state of Florida only in very limited circumstances and agents who are permitted to rebate must follow strict requirements. Rebating - returning a portion of a commission as an inducement to apply for insurance - is permitted in Florida in very limited circumstances under Florida Statute 626.572:

Example: The buyer of an insurance policy receives any part of the insurance producer’s commission or anything else of significant value as an inducement to purchase the insurance product being sold by the insurance producer. Rebating is not illegal in the state of Florida: Florida (Rules specific to the allowance of rebating are found in the 2012 Florida Statues, Title XXXVII, Section 626.572). However, most insurers forbid their insurance producers to rebate even in jurisdictions where it is legal. It is acceptable to provide gifts of nominal value (pens, calendars,
coffee mugs, etc.) to prospects and clients when those gifts are given regardless of whether or not you make a sale. If you provide a nominal gift, you must provide it to everyone you approach.

**Penalties** - Following an investigation and a hearing, if the DFS or OIR finds that any agent or insurer is engaged in any unfair marketing practices or unfair claims practice, the Commissioner may issue a cease and desist order prohibiting the agent or insurer from continuing the practice. Failure to comply with the cease and desist order can result in a substantial fine (usually $10,000). In addition, fines and loss of license may also be imposed for any agent or insurer guilty of violating the Unfair Marketing & Trade Practices Act. The DFS may also issue a consent order, a disciplinary action in which the party at fault (the agent or insurer) agrees to discontinue a particular practice (usually an unfair marketing practice or claims practice), through a written agreement with the DFS. Usually the individual denies the allegations but consents to the action taken by the department. Consent orders (also known as consent decrees) may or may not involve a fine.

- According to 626.9521(2), F.S., unfair methods of competition and unfair or deceptive acts or practices prohibited; Penalties, any person who violates any provision of this part is subject to a fine in an amount not greater than $2,500 for each non-willful violation and not greater than $20,000 for each willful violation. Fines under this subsection may not exceed an aggregate amount of $10,000 for all non-willful violations arising out of the same action, or an aggregate amount of $100,000 for all willful violations arising out of the same action. The fines may be imposed, in addition to any other applicable.
- According to F. S. 626.9521(3)(b), if a person violates the offense of either twisting or churning, the person commits a misdemeanor of the first degree, punishable as provided in F.S. 775.082, and an administrative fine not greater than $5,000 for each non-willful violation or an administrative fine, not greater than $75,000 for each willful violation. To impose an administrative fine for a willful violation under this section, the practice of twisting or churning must involve fraudulent conduct.

### E. Understanding required premium discounts

**UNDERSTANDING REQUIRED PREMIUM DISCOUNTS**

In the life and health insurance arena, insurers are not legally required to offer premium discounts to applicants and policyholders. However, a history of good health may help applicants qualify for low (discounted) life insurance and health insurance premiums when they apply for coverage.

A number of life insurance companies now offer the opportunity to earn discounts through so called “Wellness for Life programs,” an optional rider made available on universal life and indexed universal life products. The concept is similar to saving on car insurance by being a safe driver, or saving on your health plan at work by participating in a company wellness program.

If an applicant chooses the rider, he or she will pay a one-time fee ($100-$150) and qualify for premium discounts or greater cash accumulation through the life of the policy by maintaining a healthy weight and having a physical examination at least every other year.

At this time the DFS does not have any regulations on these types of premium discounts.
Chapter 3 Review Questions

1. Agent John Brickland unintentionally made a misrepresentation, although he believed he was being truthful. This is a defense against liability for misrepresentation, because John thought he was telling the truth. (Page 41)
   a. True
   b. False

2. In Florida, all of the following are unfair methods of competition and false advertising **EXCEPT:**
   (Page 55)
   a. Advertising a gift with a value of less than $100.00 in aggregate
   b. Misrepresenting the benefits of any insurance policy
   c. Using an advertisement which misleads people into thinking that the agent is endorsed by the federal government
   d. Misrepresenting an insurance policy to be shares of stock

3. Using misrepresentation or fraud to induce a policyholder to replace one policy for another with a different insurer is called:
   (Page 41)
   a. Twisting
   b. Churning
   c. Rebating
   d. Dual Agency

4. When an insurance agent carefully aligns the client’s needs and objectives with an insurance product it is called:
   (Page 48)
   a. Financial planning
   b. Suitability
   c. Risk management
   d. Estate planning
IV. Disciplinary and industry trends

Overview and Learning Objectives

The overall objective of this course was to educate agents on the new state and federal laws and regulations that impact the insurance industry as well as their ethical duties and responsibilities as an insurance producer doing business in the state of Florida. In addition, we reviewed the role and responsibilities of the DFS and OIR and the new initiatives they have taken to enhance communications with agents and insurers and to provide consumers with additional product information.

Upon completion of this chapter, agents will have an understanding of the reasons for some recent enforcement actions taken by the DFS, the issues involved with the sale of unauthorized insurers selling phony insurance, and the penalties assessed to insurance professionals who sell those policies.

A. An Update on the 2018 Legislation

Insurance HB 465

CS/CS/HB 465 passed the House on March 5, 2018, and subsequently passed the Senate on March 9, 2018.

The bill makes the following changes regarding insurance:

Foreign Insurer Stock Valuation—provides that the stock of a subsidiary corporation or related entity of a foreign insurer is exempt from certain limitations on valuation and investment requirements for solvency evaluation purposes in certain circumstances.

Exemption to Adjuster Examination Requirement—provides an exemption to the all-lines adjuster licensing exam to individuals who receive a Claims Adjuster Certified Professional (CACP) designation from WebCE, Inc.

Surplus Lines Insurer Eligibility—repeals a requirement that conflicts with federal law.

Personal Financial and Health Information Privacy—incorporates a recent amendment of the Gramm-Leach-Bliley Act for purposes of privacy standards applicable to certain notices.

Execution of Insurance Policies—provides that an insurer may elect to issue a policy that is not executed by one of the specified insurer representatives and that the policy is not invalid despite not being executed.

Notice of Policy Change—requires that a property and casualty insurer summarize policy changes on the required Notice of Change in Policy Terms that is issued at policy renewal, rather than merely issuing a notice that the policy has changed.

Property Insurance Claim Mediation—provides that a third-party assignee may request mediation of property insurance claims; except, an insurer is not required to participate in mediations requested by the assignee.
Proof of Mailing—permits motor vehicle insurers to use the Intelligent Mail barcode, or similar method approved by the United States Postal Service, to document proof of mailing of certain required notices.

Filing Exception for Specialty Insurers—authorizes specialty insurers to overcome a presumption of control regarding acquisition of stocks, interests, and assets of other companies in the same manner as insurers.

Confidentiality of Documents Submitted to the Office of Insurance Regulation (OIR) – expands the confidentiality of documents submitted to the OIR under Own-Risk and Solvency Assessment requirements to make them inadmissible as evidence in any private civil action, regardless of from whom they were obtained, rather than only when they are obtained from OIR.

Reciprocal Insurer Reserve Requirements -- revises unearned premium reserve requirements.

Delivery of Policies – authorizes motor vehicle service agreement companies and health maintenance organizations (HMO) to deliver agreements and HMO contracts, respectively, in the same manner as currently required for insurers, including the posting of boilerplate contents on a website and requiring delivery within 60 days, rather than 45 days and 10 days, respectively. The bill was approved by the Governor on March 30, 2018, ch. 2018-131, L.O.F., and became effective on that date.

Unfair Insurance Trade Practices HB 483

CS/CS/HB 483 passed the House on February 14, 2018, and subsequently passed the Senate on March 9, 2018.

The Unfair Insurance Trade Practices Act provides an extensive list of unfair methods of competition and unfair or deceptive acts prohibited in the business of insurance. Among these are prohibitions on certain inducements to the purchase of insurance; however, there are also exceptions provided by law. Among the exceptions is authorization for insurers and their agents to offer and make gifts of merchandise up to $25 per gift to an insured, prospective insured, or any person, for the purpose of advertising. This exception restricts the value of the advertising gift, but it does not limit the frequency of giving or the aggregate value of gifts given over any period of time. The $25 limit has been in place since 1989.

The bill expands the exception for advertising gifts to:

- Allow gifting of goods, wares, store gift cards, gift certificates, event tickets, anti-fraud or loss mitigation services, and other items, in addition to merchandise;
- Authorize charitable contributions in the name of insureds or prospective insureds, up to the specified limit;
- Remove the limitation that the gifts be for advertising purposes;
- Increase the maximum allowed value from $25 to $100 per insured or prospective insured; and
- Limit the total value given to any insured or prospective insured to $100 in one calendar year.

In relation to advertising gifts by title insurance agents, agencies, and insurers, the bill maintains the existing gift limit applicable to them (i.e., limits them to an aggregate $100 gift value with no annual aggregate limitation).

The bill was approved by the Governor on April 6, 2018, ch. 2018-149, L.O.F., and will become effective on July 1, 2018.
Direct Primary Care Agreements HB 37 Effective Date: 7/1/2018

HB 37 passed the House on January 25, 2018, and subsequently passed the Senate on March 8, 2018. The bill creates s. 624.27, F.S., to provide that a direct primary care agreement (agreement) and the act of entering into such an agreement are not insurance and not subject to regulation under the Florida Insurance Code (Code), including chapter 636, F.S. The bill also exempts a primary care provider, which includes a primary care group practice, or his or her agent, from any certification or licensure requirements in the Code for marketing, selling, or offering to sell an agreement. An agreement must:

- Be in writing;
- Be signed by the primary care provider, or his or her agent, and the patient, or the patient's legal representative;
- Allow either party to terminate the agreement by written notice followed by, at least, a 30 day waiting period;
- Allow immediate termination of the agreement for a violation of physician-patient relationship or a breach of the terms of the agreement;
- Describe the scope of services that are covered by the monthly fee;
- Specify the monthly fee and any fees for services not covered under the agreement;
- Specify the duration of the agreement and any automatic renewal provisions;
- Provide for a refund to the patient of monthly fees paid in advance if the primary care provider stops offering primary care services for any reason;
- State that the agreement is not health insurance and that the primary care provider will not file any claims against the patient’s health insurance policy or plan for reimbursement for any primary care services covered by the agreement;
- State that the agreement does not qualify as minimum essential coverage to satisfy the individual responsibility provision of the Patient Protection and Affordable Care Act; and
- State that the agreement is not workers’ compensation insurance and may not replace the employer’s obligations under chapter 440, F.S.

The bill was approved by the Governor on March 23, 2018, ch. 2018-89, L.O.F., and will become effective on July 1, 2018.

Workers’ Compensation Benefits for First Responders SB 376 Effective Date: 10/1/2018

CS/CS/SB 376 revises the standards for determining compensability of employment-related post-traumatic stress disorder (PTSD) under workers’ compensation for first responders, which includes volunteers or employees engaged as law enforcement officers, firefighters, emergency medical technicians, and paramedics.

The bill allows first responders that meet certain conditions to access indemnity and medical benefits for PTSD without an accompanying physical injury.

Current law provides only medical benefits for a mental or nervous injury without an accompanying physical injury and requires the first responder to incur a compensable physical injury to receive indemnity benefits for a mental or nervous injury.
Generally, the bill will increase the likelihood of compensability for workers’ compensation indemnity benefits for PTSD.

PTSD is a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war, combat, rape, or other violent personal assault. A diagnosis of PTSD requires direct or indirect exposure to an upsetting traumatic event.

The bill creates an exception to current law to authorize the compensation of indemnity benefits for PTSD, if the first responder:

- Has PTSD that resulted from the course and scope of employment; and
- Is examined and diagnosed with PTSD by an authorized treating psychiatrist of the employer or carrier due to the first responder experiencing one of the following qualifying events relating to minors or others:
  - Seeing for oneself a deceased minor;
  - Witnessing directly the death of a minor;
  - Witnessing directly the injury to a minor who subsequently died prior to, or upon arrival at a hospital emergency department, participating in the physical treatment of, or manually transporting an injured minor who subsequently died before or upon arrival at a hospital emergency department;
  - Seeing for oneself a decedent who died due to grievous bodily harm of a nature that shocks the conscience;
  - Witnessing directly a death, including suicide, due to grievous bodily harm; or homicide, including murder, mass killings, manslaughter, self-defense, misadventure, and negligence; or
  - Participating in the physical treatment of an injury, including attempted suicide, or manually transporting an injured person who suffered grievous bodily harm, if the injured person subsequently died prior to or upon arrival at a hospital emergency department.

Medical and indemnity benefits for a first responder’s PTSD are due regardless of whether the first responder incurred a physical injury, and the following provisions do not apply:

- “Apportionment” due to a preexisting PTSD;
- The one percent limitation on permanent psychiatric impairment benefits; or
- Any limitation on temporary benefits under s.440.093, F.S.

The first responder must file the notice of injury with their employer or carrier within 90 days of the qualifying event, described above, or manifestation of the PTSD. However, the claim is barred if it is not filed within 52 weeks of the qualifying event.

The bill requires an employing agency of a first responder, including volunteer first responders, to provide educational training related to mental health awareness, prevention, mitigation, and treatment.

The bill provides that the Legislature determines and declares that this act fulfills an important state interest.

State and local governments may incur additional costs as a result of the implementation of this bill. The National Council on Compensation Insurance estimates the fiscal impact of the bill on Florida’s workers’ compensation system is approximately 0.2 percent, or approximately $7 million.
The bill is effective October 1, 2018.

**Unfair Insurance Trade Practices HB 533 Effective Date: 7/1/2018**

CS/HB 533 passed the House on January 31, 2018. The bill was amended by the Senate on March 8, 2018, and was passed by the Senate and returned to the House on March 9, 2018. The House concurred in the Senate amendment and subsequently passed the bill, as amended, on March 9, 2018.

The Unfair Insurance Trade Practices Act provides an extensive list of unfair methods of competition and unfair or deceptive acts prohibited in the business of insurance. Among these is a prohibition on an insurer refusing to insure anyone solely because they have not bought the following services related to the ownership and use of a motor vehicle:

- Towing service;
- Procuring group coverage from an insurer for bail and arrest bonds or for accidental death and dismemberment;
- Emergency service;
- Procuring prepaid legal services, or providing reimbursement for legal services;
- Offering assistance in locating or recovering stolen or missing motor vehicles; or
- Paying emergency living and transportation expenses of the owner of a motor vehicle related to a damaged motor vehicle.

The bill allows a property and casualty insurer to condition the sale of insurance on the purchase of motor vehicle services if such services are purchased from a membership organization that is affiliated with the property and casualty insurer. The property and casualty insurer and its affiliated membership organization must have been affiliated on January 1, 2018.

The bill has no fiscal impact on state or local government expenditures. The bill has indeterminate impacts on the private sector.

The bill was approved by the Governor on April 6, 2018, ch. 2018-153, L.O.F., and will become effective on July 1, 2018.

**Homeowners’ Insurance Policy Disclosures HB 1011 Effective Date: 1/1/2019**

CS/Cs/HB 1011 passed the House on February 14, 2018, and subsequently passed the Senate on March 2, 2018.

The bill provides that insurance policies, depending on the type of coverage, include specific content to provide consumers with important information or ensure consistency and readability of insurance contracts from different insurers. Such provisions may establish requirements regarding content, print type or size, and appearance (e.g., bold type or all capitalized text). Homeowner’s property insurance policies must include the following statement in bold 18-point type:
“LAW AND ORDINANCE COVERAGE IS AN IMPORTANT COVERAGE THAT YOU MAY WISH TO PURCHASE. YOU MAY ALSO NEED TO CONSIDER THE PURCHASE OF FLOOD INSURANCE FROM THE NATIONAL FLOOD INSURANCE PROGRAM. WITHOUT THIS COVERAGE, YOU MAY HAVE UNCOVERED LOSSES. PLEASE DISCUSS THESE COVERAGES WITH YOUR INSURANCE AGENT.”

Flood insurance is a separate line of insurance from homeowner’s property insurance and is not included in such a policy. The windstorm portion of the homeowner’s property insurance policy, which many think of as “hurricane insurance,” does not cover the flood damage from rising or accumulating surface water. If the homeowner does not separately purchase flood insurance through the National Flood Insurance Program, or from an authorized Florida flood insurer, then their flood damages will not be covered.

The bill revises the current notice to require the following statement on an initial policy and every renewal:

"LAW AND ORDINANCE: LAW AND ORDINANCE COVERAGE IS AN IMPORTANT COVERAGE THAT YOU MAY WISH TO PURCHASE. PLEASE DISCUSS WITH YOUR INSURANCE AGENT."

"FLOOD INSURANCE: YOU MAY ALSO NEED TO CONSIDER THE PURCHASE OF FLOOD INSURANCE. YOUR HOMEOWNER’S INSURANCE POLICY DOES NOT INCLUDE COVERAGE FOR DAMAGE RESULTING FROM FLOOD EVEN IF HURRICANE WINDS AND RAIN CAUSED THE FLOOD TO OCCUR. WITHOUT SEPARATE FLOOD INSURANCE COVERAGE, YOU MAY HAVE UNCOVERED LOSSES CAUSED BY FLOOD. PLEASE DISCUSS THE NEED TO PURCHASE SEPARATE FLOOD INSURANCE COVERAGE WITH YOUR INSURANCE AGENT."

The bill has no fiscal impact on state or local government revenues and expenses. The bill has indeterminate impacts on the private sector.

The bill was approved by the Governor on March 21, 2018, ch. 2018-63, L.O.F., and will become effective on January 1, 2019.

B. An Update on the 2019 Legislation

Department of Financial Services (HB 1393 by Clemons) Effective Date: July 1, 2019 House Bill 1393 revises requirements for cemetery companies licenses, combination funeral director & embalmer internships, funeral establishments, embalming facilities, disposition of proceeds from preneed contracts, preneed contracts, direct disposal establishments, & incinerator facilities; requires preneed licensees to provide certain persons with written notice of intent to distribute funds under preneed contract; revises requirements for nonrenewable temporary license, lines insurance licenses, & nonresident public adjuster's licenses; authorizes luxury ground transportation network companies to elect to be regulated as transportation network companies; and establishes Florida Blockchain Task Force.

Direct HealthCare Agreements HB 7 Effective Date: 7/1/2019

House Bill 7 expands scope of direct primary care agreements to direct health care agreements.

Telehealth HB 23 Effective Date: 7/1/2019
House Bill 23 establishes standard of care for telehealth providers; authorizes telehealth providers to use telehealth to perform patient evaluations; authorizes certain telehealth providers to use telehealth to prescribe specified controlled substances; provides that a non-physician telehealth provider using telehealth & acting within scope of practice is not deemed to be practicing medicine without license; provides that a health insurer or HMO is allowed tax credit against specified tax imposed if it covers services provided by telehealth providers.

**Health Plans SB 322** Effective Date: June 25, 2019

Senate Bill 322 revises eligibility requirements for multiple-employer welfare arrangements; authorizing health insurers and health maintenance organizations to create new health insurance policies and health maintenance contracts meeting certain criteria for essential health benefits under the federal Patient Protection and Affordable Care Act (PPACA); and revises applicability of requirements relating to preexisting conditions, etc.

**Firefighters SB 426** Effective Date: 7/1/2019

Senate Bill 426 grants certain benefits to a firefighter upon receiving a diagnosis of cancer if certain conditions are met; requires an employer to make certain disability payments to a firefighter in the event of a total and permanent disability; provides for death benefits to a firefighter's beneficiary if a firefighter dies as a result of cancer or cancer treatments; and adjusts the allocation of funds to provide line-of-duty death benefits for members in the investment plan of the Florida Retirement System, etc.

**Insurer Guarantee Associations HB673** Effective Date: June 7, 2019

House Bill 673 revises membership of Florida Life & Health Insurance Guaranty Association's board; specifies requirements relating to director of Florida Health Maintenance Organization Consumer Assistance Plan to be confirmed to association's board; specifies duties of association as to potential long-term care insurer impairments or insolvencies, sharing information, & providing assistance to plan's board; requires that DFS, rather than receivership court, approve certain alternative policies or contracts; authorizes association's board to file directly for an actuarially justified rate or premium increases; specifies calculation & allocation of Class B assessments for long-term care insurance; and specifies a limit on certain assessments on a member insurer or member HMO.

**Health Care HB 843** Effective Date: July 1, 2019

House Bill 843 establishes the Dental Student Loan Repayment Program to support dentists who practice in public health programs located in certain underserved areas; requires the Department of Health to establish the Donated Dental Services Program to provide comprehensive dental care to certain eligible individuals; requires a hospital to notify a patient's primary care provider within a specified timeframe after the patient's admission; requires a licensed facility, upon placing a patient on observation status, to immediately notify the patient of such status using a specified form; and prohibits certain health maintenance organizations from employing step-therapy protocols under certain circumstances, etc.
Continuing Care Contracts HB 1033 Effective Date: January 1, 2020

House Bill 1033 revises and provides provisions related to continuing care contracts including financing, refinancing, procedures & standards for certificates of authority & provisional certificates, escrowed funds, provider acquisitions, expansion of facilities, rulemaking, filing of information, management contracts, minimum standards, procedures for providers not meeting standards, & composition of Continuing Care Advisory Council.

Health Insurance Savings Programs HB 1113 Effective Date: July 1, 2019

House Bill 1113 authorizes health insurers to provide shared savings incentive programs in which insureds receive cash payment as incentive to save on certain nonemergency health care services; provides shared savings incentive amount does not institute income to insureds; provides that shared savings incentives are not administrative expenses for insurers; and provides tax reductions for insurers.

Autonomous Vehicles HB 311 Effective Date: July 1, 2019

House Bill 311 exempts autonomous vehicles & operators from certain prohibitions; provides that human operator is not required to operate fully autonomous vehicle; authorizes a fully autonomous vehicle to operate regardless of presence of a human operator; provides that an automated driving system is deemed operator of autonomous vehicle operating with system engaged; authorizes Florida Turnpike Enterprise to enter into agreements to fund & operate facilities; provides requirements for insurance & operation of on-demand autonomous vehicle networks; revises registration requirements for autonomous vehicles; and provides for uniformity of laws governing autonomous vehicles.

Homeowners' Insurance Policy Disclosures HB 617 Effective Date: July 1, 2019

House Bill 617 revises circumstances under which insurers issuing homeowners' insurance policies must include a specified statement relating to flood insurance with policy documents at initial issuance & renewals.

Lessor Liability Under Special Mobile Equipment Leases SB 862 Effective Date: July 1, 2019

Senate Bill 862 provides that a lessor of special mobile equipment that causes injury, death, or damage is not liable for certain acts of the lessee or lessee’s agent if the lease agreement requires documented proof of specified insurance coverage; and provides that a lessee’s failure to have in effect the required coverage does not impose liability on the lessor, etc.

Warranty Associations HB 925 Effective Date: July 1, 2019

House Bill 925 revises requirements for home warranty associations including account assets, types of accounts, & compliance with laws where they operate; prohibits home warranties from excluding coverage for presence of rust or corrosion; provides requirements for coverage exclusions of certain HVAC components; and revises requirements for service warranty associations including account assets, types of accounts, & compliance with laws where they operate.
Insurance Assignment Agreements HB 7065 Effective Date: July 1, 2019

House Bill 7065 provides requirements and limitations for property insurance assignment agreements; providing a burden of proof; providing that an assignment agreement does not affect managed repair arrangements under a property insurance policy; provides that an acceptance by an assignee of an assignment agreement is a waiver by the assignee and its subcontractors of certain claims against an insured; specifies an insured's payment obligations under an assignment agreement; and requires notice of intent to initiate litigation, etc.

OGSR/Hurricane and Flood Loss Model Trade Secrets HB 7091 Effective Date: October 1, 2019

House Bill 7091 removes scheduled repeal of an exemption relating to certain information related to trade secrets used to design an insurance hurricane or flood loss model.

C. Recent Cases

The following are instances in which licensees or other persons violated the Florida Insurance Code and the administrative action the Department has taken against them. Note: All administrative investigations are subject to referral to the Division of Investigative & Forensic Services for criminal investigation.

Before referring to specific cases, it’s worth pointing out the most common disciplinary action is license revocation for convictions for other crimes unrelated to the insurance industry. A licensed agent must be aware that their license is another thing they will lose as consequences for unlawful acts, in addition to any and all fines, incarceration, or lost standing within the community.

Case: An agent in California, holding a non-resident license in Florida, sold an event insurance policy to a band of musicians, also in California. One of the musicians sent the agent a check to pay his premium, but the agent endorsed it himself, and kept the money. The insurer eventually cancelled the musicians’ policy for non-payment, and the musicians found themselves without insurance coverage for an event they had paid for.

Disposition: Non-resident license in Florida revoked, along with any and all other criminal penalties assessed in California.

Case: An investigation into an agent had led to an Administrative Complaint being filed against that agent. The agent was notified via certified mail from the USPS with return service requested, to no response. An email was also sent to the agent’s address on file, which was also not responded to.

Disposition: Since non-response to Administrative Complaints indicate a decision by the agent to waive all rights to respond (explain her side of the story, examine evidence, or to confront witnesses, etc.), the charge in the complaint was upheld. License revoked, without the right to reapply for two years.

Case: An investigation was opened after receiving a complaint from an insurer's Special Investigative Unit (SIU) alleging a life, health and variable annuity agent misrepresented the replacement of an existing annuity on a new annuity application and did not submit the required replacement and annuity disclosure forms. In their statement to investigators, the senior consumers said they were misled by the agent’s advertised "bonus" rate of 20% which...
motivated them to surrender their annuities. The agent instructed the consumers to notify him when they received their checks. Surrender charges totaling more than $16,000 were assessed and the failure to file for a 1035 Exchange resulted in a taxable event.

Disposition: Fined $6,500.

Case: An investigation was opened on a life, health and variable annuity agent when consumers filed complaints with the insurer regarding the replacement of 28 annuity contracts and life insurance policies. Investigators met with the consumers and reviewed application documents and found many included false information which the consumers attested to in their statement to investigators. During the investigation, investigators also determined the agent enlisted the help of several insurance agents to target policies of an elderly couple who had recently relocated to Florida.

Disposition: License revoked.
Chapter 4 Review Questions

1. The DFS publishes a list of cases involving agents, agencies, and unlicensed individuals who violate Florida’s insurance rules and regulations in the _______.
   a) Insurance Insights
   b) Division of Fraud annual report
   c) MyProfile
   d) Financial Frontlines

2. "Policies" issued by unauthorized "insurers" are covered by the state guarantee fund, protecting the public from the sale of insurance by unlicensed entities.
   a) True
   b) False

3. Possible consequences for acting as an insurer without a proper license or aiding and abetting an unauthorized insurer include all of the following **EXCEPT:**
   a) Conviction of a third-degree felony
   b) Liability for all unpaid claims
   c) Suspension or revocation of all insurance licenses
   d) Conviction of a first-degree misdemeanor

4. In the state of Florida, the “Free Look” period is how many days?
   a) 21 days
   b) 14 days
   c) 30 days
   D) 60 days
Chapter Review Answers

A. Chapter 1
1. d Pg 5 p 4
2. a Pg 8 p 2
3. a Pg 11 p 8
4. b Pg 23 p 10

B. Chapter 2
1. a Pg 32 p 4
2. c Pg 35 p 1
3. b Pg 35 p 2
4. d Pg 32 p 3

C. Chapter 3
1. b Pg 65 p 6
2. a Pg 24 p 2
3. a Pg 59 p 7
4. b Pg 41 p 9

D. Chapter 4
1. a Pg 26 p 2
2. b Pg 77 p 7
3. d Pg 78 p 6
4. b Pg 83 p 7