By the Committees on Appropriations; and Banking and Insurance; and Senators Brandes and Young

576-04389-17 20171012c2

A bill to be entitled

An act relating to insurance fraud; reordering and amending s. 626.9891, F.S.; defining and revising definitions; requiring every insurer to designate at least one primary anti-fraud employee for certain purposes; requiring insurers to adopt an anti-fraud plan; revising insurer requirements in providing anti-fraud information to the Department of Financial Services; requiring specified information to be filed annually with the department; revising the information to be provided by insurers who write workers' compensation insurance; requiring each insurer to provide annual anti-fraud education and training; requiring insurers who submit an application for a certificate of authority after a specified date to comply with the section; providing penalties for the failure to comply with requirements of the section; requiring the Division of Investigative and Forensic Services of the department to create, by a specified date, a report detailing best practices for the detection, investigation, prevention, and reporting of insurance fraud and other fraudulent insurance acts; requiring such report to be updated at certain intervals; specifying required information in the report; requiring the department to adopt rules relating to insurers' annual reporting of certain data; creating s. 626.9896, F.S.; providing legislative intent; creating a grant program to fund the Insurance Fraud Dedicated Prosecutor Program

within the department; requiring moneys that are appropriated for the program be used to fund specific attorney and paralegal positions; specifying procedures to be used by state attorneys' offices when applying for biennial grants; specifying that grants are for 2 years but authorizing the division to renew the grants; specifying procedures to be used by the department in awarding grant funds; requiring the Division of Investigative and Forensic Services to provide an annual report to the Executive Office of the Governor, the Speaker of the House of Representatives, and the Senate President; specifying information to be contained in the report; authorizing the department to adopt rules to administer and implement the insurance fraud dedicated prosecutor program; amending s. 626.9911, F.S.; defining the terms "fraudulent viatical settlement act" and "stranger-originated life insurance practice" for purposes of provisions relating to the Viatical Settlement Act; amending ss. 626.9924 and 626.99245, F.S.; conforming cross-references; amending s. 626.99275, F.S.; providing additional prohibited acts related to viatical settlement contracts; amending s. 626.99287, F.S.; providing that a viatical settlement contract is void and unenforceable by either party if the viatical settlement policy is subject, within a specified timeframe, to a loan secured by an interest in the policy; revising conditions and requirements in which viatical settlement contracts entered into

within specified timeframes are valid and enforceable; deleting provisions related to the transfer of insurance policies or certificates to viatical settlement providers; creating s. 626.99289, F.S.; providing that certain contracts, agreements, arrangements, or transactions relating to stranger-originated life insurance practices are void and unenforceable; creating s. 626.99291, F.S.; authorizing a life insurer to contest policies obtained through such practices; creating s. 626.99292, F.S.; requiring life insurers to provide a specified statement to individual life insurance policyholders; authorizing such statements to accompany or be included in notices or mailings provided to the policyholders; requiring such statements to include contact information; amending s. 627.744, F.S.; deleting a provision that provides construction; authorizing insurers to opt out of the preinsurance inspection requirements for private passenger motor vehicles; requiring insurers opting out to file a certain manual rule with the Office of Insurance Regulation; authorizing such insurers to establish their own preinsurance inspection requirements, which must be included in the filed manual rule; prohibiting such insurers from requiring applicants to pay for the cost of inspections; deleting an obsolete provision; amending s. 641.3915, F.S.; deleting obsolete provisions; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Effective September 1, 2017, section 626.9891, Florida Statutes, is reordered and amended to read:

626.9891 Insurer anti-fraud investigative units; reporting requirements; penalties for noncompliance.—

(1)~~(5)~~ As used in ~~For purposes of~~ this section, the term:

(a) "Anti-fraud investigative unit" means the designated anti-fraud unit or division, or contractor authorized under subparagraph (2)(a)2.

(b) "Designated anti-fraud unit or division" includes a distinct unit or division or a unit or division made up of ~~the assignment of fraud investigation to~~ employees whose principal responsibilities are the investigation and disposition of claims who are also assigned investigation of fraud. ~~If an insurer creates a distinct unit or division, hires additional employees, or contracts with another entity to fulfill the requirements of this section, the additional cost incurred must be included as an administrative expense for ratemaking purposes.~~

(2)~~(1)~~ By December 31, 2017, every insurer admitted to do business in this state ~~who in the previous calendar year, at any time during that year, had $10 million or more in direct premiums written~~ shall:

(a)1. Establish and maintain a designated anti-fraud unit or division within the company to investigate and report possible fraudulent insurance acts ~~claims~~ by insureds or by persons making claims for services or repairs against policies held by insureds; or

2.~~(b)~~ Contract with others to investigate and report possible fraudulent insurance acts by insureds or by persons making claims for services or repairs against policies held by insureds.

(b) Adopt an anti-fraud plan.

(c) Designate at least one employee with primary responsibility for implementing the requirements of this section.

(d) Electronically ~~An insurer subject to this subsection shall~~ file with the Division of Investigative and Forensic Services of the department, and annually thereafter ~~on or before July 1, 1996~~, a detailed description of the designated anti-fraud unit or division ~~established pursuant to paragraph (a)~~ or a copy of the contract executed under subparagraph (a)2., as applicable, a copy of the anti-fraud plan, and the name of the employee designated under paragraph (c) ~~and related documents required by paragraph (b)~~.

An insurer must include the additional cost incurred in creating a distinct unit or division, hiring additional employees, or contracting with another entity to fulfill the requirements of this section, as an administrative expense for ratemaking purposes.

~~(2) Every insurer admitted to do business in this state, which in the previous calendar year had less than $10 million in direct premiums written, must adopt an anti-fraud plan and file it with the Division of Investigative and Forensic Services of the department on or before July 1, 1996. An insurer may, in lieu of adopting and filing an anti-fraud plan, comply with the~~

~~provisions of subsection (1).~~

(3) Each ~~insurers~~ anti-fraud plan must ~~plans shall~~ include:

(a) An acknowledgement that the insurer has established procedures for detecting and investigating possible fraudulent insurance acts relating to the different types of insurance by that insurer ~~A description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts~~;

(b) An acknowledgment that the insurer has established ~~A description of the insurer's~~ procedures for the mandatory reporting of possible fraudulent insurance acts to the Division of Investigative and Forensic Services of the department;

(c) An acknowledgement that the insurer provides the ~~A description of the insurer's plan for~~ anti-fraud education and training required by this section to the anti-fraud investigative unit ~~of its claims adjusters or other personnel~~; ~~and~~

(d) A description of the required anti-fraud education and training;

(e) A ~~written~~ description or chart ~~outlining~~ ~~the organizational arrangement~~ of the insurer's anti-fraud investigative unit, including the position titles and descriptions of staffing; and ~~personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts~~

(f) The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit which may include objective criteria, such as the number of policies written, the number of claims received on an annual basis, the volume of suspected fraudulent claims detected on an annual

basis, an assessment of the optimal caseload that one investigator can handle on an annual basis, and other factors.

(4) By December 31, 2018, each insurer shall provide staff of the anti-fraud investigative unit at least 2 hours of initial anti-fraud training that is designed to assist in identifying and evaluating instances of suspected fraudulent insurance acts in underwriting or claims activities. Annually thereafter, an insurer shall provide such employees a 1-hour course that addresses detection, referral, investigation, and reporting of possible fraudulent insurance acts for the types of insurance lines written by the insurer.

(5) Each insurer is required to report data related to fraud for each identified line of business written by the insurer during the prior calendar year. The data shall be reported to the department by March 1, 2019, and annually thereafter, and must include, at a minimum:

(a) The number of policies in effect;

(b) The amount of premiums written for policies;

(c) The number of claims received;

(d) The number of claims referred to the anti-fraud investigative unit;

(e) The number of other insurance fraud matters referred to the anti-fraud investigative unit that were not claim related;

(f) The number of claims investigated or accepted by the anti-fraud investigative unit;

(g) The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that were not claim related;

(h) The number of cases referred to the Division of

Investigative and Forensic Services;

(i) The number of cases referred to other law enforcement agencies;

(j) The number of cases referred to other entities; and

(k) The estimated dollar amount or range of damages on cases referred to the Division of Investigative and Forensic Services or other agencies.

(6) In addition to providing information required under subsections (2), (4), and (5), each insurer writing workers' compensation insurance shall also report the following information to the department, on or before March 1, 2019, and annually thereafter ~~August 1 of each year, on its experience in implementing and maintaining an anti-fraud investigative unit or an anti-fraud plan. The report must include, at a minimum~~:

(a) The estimated dollar amount of losses attributable to workers' compensation fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other type.

(b) The estimated dollar amount of recoveries attributable to workers' compensation fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other type.

(c) The number of cases referred to the Division of Investigative and Forensic Services, delineated by the type of fraud, including claimant, employer, provider, agent, or other type.

~~(a) The dollar amount of recoveries and losses attributable to workers' compensation fraud delineated by the type of fraud: claimant, employer, provider, agent, or other.~~

~~(b) The number of referrals to the Bureau of Workers' Compensation Fraud for the prior year.~~

~~(c) A description of the organization of the anti-fraud investigative unit, if applicable, including the position titles and descriptions of staffing.~~

~~(d) The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit, which may include objective criteria such as number of policies written, number of claims received on an annual basis, volume of suspected fraudulent claims currently being detected, other factors, and an assessment of optimal caseload that can be handled by an investigator on an annual basis.~~

~~(e) The inservice education and training provided to underwriting and claims personnel to assist in identifying and evaluating instances of suspected fraudulent activity in underwriting or claims activities.~~

~~(f) A description of a public awareness program focused on the costs and frequency of insurance fraud and methods by which the public can prevent it~~.

(7) ~~(4)~~ An ~~Any~~ insurer who obtains a certificate of authority has 6 ~~after July 1, 1995, shall have 18~~ months in which to comply with subsection (2), and one calendar year thereafter, to comply with subsections (4), (5), and (6) ~~the requirements of this section~~.

(8) ~~(7)~~ If an insurer fails ~~to timely submit a final acceptable anti-fraud plan or anti-fraud investigative unit description, fails to implement the provisions of a plan or an anti-fraud investigative unit description,~~ or otherwise refuses to comply with the provisions of this section, the department, office, or commission may:

(a) Impose an administrative fine of not more than $2,000

per day for such failure ~~by an insurer to submit an acceptable anti-fraud plan or anti-fraud investigative unit description,~~ until the department, office, or commission deems the insurer to be in compliance;

(b) Impose an administrative fine for failure by an insurer to implement or follow the provisions of an anti-fraud plan or anti-fraud investigative unit description; or

(c) Impose the provisions of both paragraphs (a) and (b).

(9) On or before December 31, 2018, the Division of Investigative and Forensic Services shall create a report detailing best practices for the detection, investigation, prevention, and reporting of insurance fraud and other fraudulent insurance acts. The report must be updated as necessary but at least every 2 years. The report must provide:

(a) Information on the best practices for the establishment of anti-fraud investigative units within insurers;

(b) Information on the best practices and methods for detecting and investigating insurance fraud and other fraudulent insurance acts;

(c) Information on appropriate anti-fraud education and training of insurer personnel;

(d) Information on the best practices for reporting insurance fraud and other fraudulent insurance acts to the Division of Investigative and Forensic Services and to other law enforcement agencies;

(e) Information regarding the appropriate level of staffing and resources for anti-fraud investigative units within insurers;

(f) Information detailing statistics and data relating to

insurance fraud which insurers should maintain; and

(g) Other information as determined by the Division of Investigative and Forensic Services.

(10) ~~(8)~~ The department may adopt rules to administer this section, except that it shall adopt rules to administer subsection (5).

Section 2. Effective September 1, 2017, section 626.9896, Florida Statutes, is created to read:

626.9896 Insurance Fraud Dedicated Prosecutor Program.—

(1) LEGISLATIVE INTENT.—The Legislature recognizes the increasing problem of insurance fraud, the need to adequately investigate and prosecute insurance fraud, and the need to create a program dedicated to the prosecution of insurance fraud. The Legislature recognizes that the Division of Investigative and Forensic Services of the department can efficiently and effectively implement and monitor such a program, and can direct and reallocate resources as insurance fraud trends change and demand for prosecutorial resources shift between judicial circuits.

(2) ESTABLISHMENT OF THE INSURANCE FRAUD DEDICATED PROSECUTOR PROGRAM.—There is created within the department a grant program to fund the Insurance Fraud Dedicated Prosecutor Program. The purpose of the program is to provide grants to state attorneys' offices to fund attorney and paralegal positions that are dedicated exclusively to the prosecution of insurance fraud. The program shall consist only of funds appropriated by the state specifically for this program.

(3) GRANT APPLICATIONS.—Beginning in 2018, a state attorney's office seeking grant funds must submit an application

to the Division of Investigative and Forensic Services detailing the proposed number of dedicated prosecutors and paralegals requested for the prosecution of insurance fraud. Applications must be received by July 1 of each even-numbered year and shall identify funding needs for 2 years. Grant awards are contingent upon legislative appropriation in the Insurance Regulatory Trust Fund and Workers' Compensation Administration Trust Fund and subject to renewal by the department. The division must compile and review the timely submitted applications to establish its legislative budget request for the program for the upcoming two years.

(4) AWARD OF GRANTS.—The division is authorized to award grants to state attorneys' offices using a formula adopted by rule of the department and based on metrics and data compiled by the division which allocates funds to the judicial circuits based on trends in insurance fraud and the performance and output measures reported as required by this section. A grant awarded to a state attorney's office may only be used to fund attorney and paralegal positions that are dedicated exclusively to the prosecution of insurance fraud. Grants are subject to the provisions of s. 215.971. The division shall establish the annual maximum grant amount, based on funds appropriated to the department for funding the Insurance Fraud Dedicated Prosecutor Program.

(5) REPORTING.—The division must track and report on the effectiveness and efficiency of each state attorney's office's use of the awarded grant funds. To help complete the report, each state attorney's office that is awarded a grant under this section must submit performance and output information as

determined by the division. The report must be provided to the Executive Office of the Governor, the Speaker of the House of Representatives, and the President of the Senate by September 1, 2020, and annually thereafter. The report must include, but is not limited to, the following:

(a) The amount of grant funds received and expended by each state attorney's office;

(b) A description of the purposes for which the funds were expended, including payment of salaries, expenses, and any other costs needed to support the delivery of services;

(c) The results achieved from the expenditures made, including the number of complaints filed, the number of investigations initiated, the number of arrests made, the number of convictions, and the amount of restitution or fines paid as a result of the cases presented for prosecution.

(6) RULES.—The department may adopt rules pursuant to ss. 120.536(1) and 120.54 for the administration and implementation of the Insurance Fraud Dedicated Prosecutor Program. Such rules may establish procedures for the Insurance Fraud Dedicated Prosecutor Program, including forms to be used by the state attorney's offices. The department may establish a formula for allocating grant funds, eligibility criteria, renewal requirements, and standards for evaluating the effectiveness and efficiency of expended funds.

Section 3. Present subsections (2) through (7) of section 626.9911, Florida Statutes, are renumbered as subsections (3) through (8), respectively, present subsections (8) through (14) of that section are renumbered as subsections (10) through (16), respectively, and new subsections (2) and (9) are added to that

section, to read:

626.9911 Definitions.—As used in this act, the term:

(2) "Fraudulent viatical settlement act" means an act or omission committed by a person who knowingly, or with intent to defraud for the purpose of depriving another of property or for pecuniary gain, commits or allows an employee or agent to commit any of the following acts:

(a) Presenting, causing to be presented, or preparing with the knowledge or belief that it will be presented to or by another person, false or concealed material information as part of, in support of, or concerning a fact material to:

1. An application for the issuance of a viatical settlement contract or a life insurance policy;

2. The underwriting of a viatical settlement contract or a life insurance policy;

3. A claim for payment or benefit pursuant to a viatical settlement contract or a life insurance policy;

4. Premiums paid on a life insurance policy;

5. Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or a life insurance policy;

6. The reinstatement or conversion of a life insurance policy;

7. The solicitation, offer, effectuation, or sale of a viatical settlement contract or a life insurance policy;

8. The issuance of written evidence of a viatical settlement contract or a life insurance policy; or

9. A financing transaction for a viatical settlement contract or life insurance policy.

(b) Employing a plan, financial structure, device, scheme, or artifice relating to viaticated policies for the purpose of perpetrating fraud.

(c) Engaging in a stranger-originated life insurance practice.

(d) Failing to disclose, upon request by an insurer, that the prospective insured has undergone a life expectancy evaluation by a person other than the insurer or its authorized representatives in connection with the issuance of the life insurance policy.

(e) Perpetuating a fraud or preventing the detection of a fraud by:

1. Removing, concealing, altering, destroying, or sequestering from the office the assets or records of a licensee or other person engaged in the business of viatical settlements;

2. Misrepresenting or concealing the financial condition of a licensee, financing entity, insurer, or other person;

3. Transacting in the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority to transact such business; or

4. Filing with the office or the equivalent chief insurance regulatory official of another jurisdiction a document that contains false information or conceals information about a material fact from the office or other regulatory official.

(f) Embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policyowner, or other person engaged in the business of viatical settlements or life insurance.

(g) Entering into, negotiating, brokering, or otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained based on information that was falsified or concealed for the purpose of defrauding the policy's issuer, viatical settlement provider, or viator.

(h) Facilitating the viator's change of residency state to avoid the provisions of this act.

(i) Facilitating or causing the creation of a trust with a non-Florida or other nonresident entity for the purpose of owning a life insurance policy covering a Florida resident to avoid the provisions of this act.

(j) Facilitating or causing the transfer of the ownership of an insurance policy covering a Florida resident to a trust with a situs outside this state or to another nonresident entity to avoid the provisions of this act.

(k) Applying for or obtaining a loan that is secured directly or indirectly by an interest in a life insurance policy with intent to defraud, for the purpose of depriving another of property or for pecuniary gain.

(l) Attempting to commit, assisting, aiding, or abetting in the commission of, or conspiring to commit, an act or omission specified in this subsection.

(9) "Stranger-originated life insurance practice" means an act, practice, arrangement, or agreement to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured. Stranger-originated life insurance practices include, but are not limited to:

(a) The purchase of a life insurance policy with resources or guarantees from or through a person who, at the time of such policy's inception, could not lawfully initiate the policy and the execution of a verbal or written arrangement or agreement to directly or indirectly transfer the ownership of such policy or policy benefits to a third party.

(b) The creation of a trust or other entity that has the appearance of an insurable interest in order to initiate policies for investors, in violation of insurable interest laws and the prohibition against wagering on life.

Section 4. Subsection (7) of section 626.9924, Florida Statutes, is amended to read:

626.9924 Viatical settlement contracts; procedures; rescission.—

(7) At any time during the contestable period, within 20 days after a viator executes documents necessary to transfer rights under an insurance policy or within 20 days of any agreement, option, promise, or any other form of understanding, express or implied, to viaticate the policy, the provider must give notice to the insurer of the policy that the policy has or will become a viaticated policy. The notice must be accompanied by the documents required by s. 626.99287 ~~626.99287(5)(a) in their entirety~~.

Section 5. Subsection (2) of section 626.99245, Florida Statutes, is amended to read:

626.99245 Conflict of regulation of viaticals.—

(2) This section does not affect the requirement of ss. 626.9911(14) ~~626.9911(12)~~ and 626.9912(1) that a viatical settlement provider doing business from this state must obtain a

viatical settlement license from the office. As used in this subsection, the term "doing business from this state" includes effectuating viatical settlement contracts from offices in this state, regardless of the state of residence of the viator.

Section 6. Subsection (1) of section 626.99275, Florida Statutes, is amended to read:

626.99275 Prohibited practices; penalties.—

(1) It is unlawful for a ~~any~~ person to:

(a) ~~To~~ Knowingly enter into, broker, or otherwise deal in a viatical settlement contract the subject of which is a life insurance policy, knowing that the policy was obtained by presenting materially false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the viator or the viator's agent intended to defraud the policy's issuer.

(b) ~~To~~ Knowingly or with the intent to defraud, for the purpose of depriving another of property or for pecuniary gain, issue or use a pattern of false, misleading, or deceptive life expectancies.

(c) ~~To~~ Knowingly engage in any transaction, practice, or course of business intending thereby to avoid the notice requirements of s. 626.9924(7).

(d) ~~To~~ Knowingly or intentionally facilitate the change of state of residency of a viator to avoid the provisions of this chapter.

(e) Knowingly enter into a viatical settlement contract before the application for or issuance of a life insurance policy that is the subject of a viatical settlement contract or

during an applicable period specified in s. 626.99287(1) or (2), unless the viator provides a sworn affidavit and accompanying independent evidentiary documentation in accordance with s. 626.99287.

(f) Engage in a fraudulent viatical settlement act, as defined in s. 626.9911.

(g) Knowingly issue, solicit, market, or otherwise promote the purchase of a life insurance policy for the purpose of or with an emphasis on selling the policy to a third party.

(h) Engage in a stranger-originated life insurance practice, as defined in s. 626.9911.

Section 7. Section 626.99287, Florida Statutes, is amended to read:

626.99287 Contestability of viaticated policies.—

(1) Except as hereinafter provided, if a viatical settlement contract is entered into within the 2-year period commencing with the date of issuance of the insurance policy or certificate to be acquired, the viatical settlement contract is void and unenforceable by either party.

(2) Except as hereinafter provided, if a viatical settlement policy is subject to a loan secured directly or indirectly by an interest in the policy within a 5-year period commencing on the date of issuance of the policy or certificate, the viatical settlement contract is void and unenforceable by either party.

(3) Notwithstanding the limitations in subsections (1) and (2) ~~this limitation~~, such a viatical settlement contract is not void and unenforceable if the viator provides a sworn affidavit and accompanying independent evidentiary documentation

certifying to the viatical settlement provider that one or more of the following conditions were met during the periods applicable to the viaticated policy as stated in subsections (1) or (2):

(a) ~~(1)~~ The policy was issued upon the owner's exercise of conversion rights arising out of a group or term policy, if the total time covered under the prior policy is at least 60 months. The time covered under a group policy must be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship. ~~;~~

(b) ~~(2)~~ The owner of the policy is a charitable organization exempt from taxation under 26 U.S.C. s. 501(c)(3). ~~;~~

~~(3) The owner of the policy is not a natural person;~~

~~(4) The viatical settlement contract was entered into before July 1, 2000;~~

(c) ~~(5)~~ The viator certifies by producing independent evidence to the viatical settlement provider that one or more of the following conditions were ~~have been~~ met ~~within the 2-year period~~:

~~(a)~~1. The viator or insured is terminally or chronically ill ~~diagnosed with an illness or condition that is either:~~

~~a. Catastrophic or life threatening; or~~

~~b. Requires a course of treatment for a period of at least 3 years of long-term care or home health care;~~ and

~~2.~~ the condition was not known to the insured at the time the life insurance contract was entered into; ~~.~~

2. ~~(b)~~ The viator's spouse dies;

3. ~~(c)~~ The viator divorces his or her spouse;

4.~~(d)~~ The viator retires from full-time employment;

5.~~(e)~~ The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment;

6.~~(f)~~ The owner of the policy was the insured's employer at the time the policy or certificate was issued and the employment relationship terminated;

7.~~(g)~~ A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a petition seeking reorganization of the viator or appointing a receiver, trustee, or liquidator to all or a substantial part of the viator's assets; or

8.~~(h)~~ The viator experiences a significant decrease in income which is unexpected by the viator and which impairs his or her reasonable ability to pay the policy premium.

(d) The viator entered into a viatical settlement contract more than 2 years after the policy's issuance date and, with respect to the policy, at all times before the date that is 2 years after policy issuance, each of the following conditions is met:

1. Policy premiums have been funded exclusively with unencumbered assets, including an interest in the life insurance policy being financed only to the extent of its net cash surrender value, provided by, or fully recourse liability incurred by, the insured;

2. There is no agreement or understanding with any other person to guarantee any such liability or to purchase, or stand ready to purchase, the policy, including through an assumption

or forgiveness of the loan; and

3. Neither the insured or the policy has been evaluated for settlement.

~~If the viatical settlement provider submits to the insurer a copy of the viator's or owner's certification described above, then the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement provider, the viatical settlement agreement shall not be void or unenforceable by operation of this section. The insurer shall timely respond to such request. Nothing in this section shall prohibit an insurer from exercising its right during the contestability period to contest the validity of any policy on grounds of fraud.~~

Section 8. Section 626.99289, Florida Statutes, is created to read:

626.99289 Void and unenforceable contracts, agreements, arrangements, and transactions.—Notwithstanding s. 627.455, a contract, agreement, arrangement, or transaction, including, but not limited to, a financing agreement or any other arrangement or understanding entered into, whether written or verbal, for the furtherance or aid of a stranger-originated life insurance practice is void and unenforceable.

Section 9. Section 626.99291, Florida Statutes, is created to read:

626.99291 Contestability of life insurance policies.—Notwithstanding s. 627.455, a life insurer may contest a life insurance policy if the policy was obtained by a stranger-originated life insurance practice, as defined in s. 626.9911.

Section 10. Section 626.99292, Florida Statutes, is created to read:

626.99292 Notice to insureds.—

(1) A life insurer shall provide an individual life insurance policyholder with a statement informing him or her that if he or she is considering making changes in the status of his or her policy, he or she should consult with a licensed insurance or financial advisor. The statement may accompany or be included in notices or mailings otherwise provided to the policyholder.

(2) The statement must also advise the policyholder that he or she may contact the office for more information and include a website address or other location or manner by which the policyholder may contact the office.

Section 11. Effective January 1, 2019, section 627.744, Florida Statutes, is amended to read:

627.744 ~~Required~~ Preinsurance inspection of private passenger motor vehicles.—

(1) A private passenger motor vehicle insurance policy providing physical damage coverage, including collision or comprehensive coverage, may not be issued in this state unless the insurer has inspected the motor vehicle in accordance with this section.

(2) This section does not apply:

(a) To a policy for a policyholder who has been insured for 2 years or longer, without interruption, under a private passenger motor vehicle policy that provides physical damage coverage for any vehicle if the agent of the insurer verifies the previous coverage.

(b) To a new, unused motor vehicle purchased or leased from a licensed motor vehicle dealer or leasing company. The insurer may require:

1. A bill of sale, buyer's order, or lease agreement that contains a full description of the motor vehicle; or

2. A copy of the title or registration that establishes transfer of ownership from the dealer or leasing company to the customer and a copy of the window sticker.

For the purposes of this paragraph, the physical damage coverage on the motor vehicle may not be suspended during the term of the policy due to the applicant's failure to provide or the insurer's option not to require the documents. However, if the insurer requires a document under this paragraph at the time the policy is issued, payment of a claim may be conditioned upon the receipt by the insurer of the required documents, and no physical damage loss occurring after the effective date of the coverage may be payable until the documents are provided to the insurer.

(c) To a temporary substitute motor vehicle.

(d) To a motor vehicle which is leased for less than 6 months, if the insurer receives the lease or rental agreement containing a description of the leased motor vehicle, including its condition. Payment of a physical damage claim is conditioned upon receipt of the lease or rental agreement.

(e) To a vehicle that is 10 years old or older, as determined by reference to the model year.

(f) To any renewal policy.

(g) To a motor vehicle policy issued in a county with a

1988 estimated population of less than 500,000.

(h) To any other vehicle or policy exempted by rule of the commission. The commission may base a rule under this paragraph only on a determination that the likelihood of a fraudulent physical damage claim is remote or that the inspection would cause a serious hardship to the insurer or the applicant.

(i) When the insurer's authorized inspection service has no inspection facility either in the municipality in which the automobile is principally garaged or within 10 miles of such municipality.

(j) When the insured vehicle is insured under a commercially rated policy that insures five or more vehicles.

(k) When an insurance producer is transferring a book of business from one insurer to another.

(l) When an individual insured's coverage is being transferred and initiated by a producer to a new insurer.

~~(3) This subsection does not prohibit an insurer from requiring a preinsurance inspection of any motor vehicle as a condition of issuance of physical damage coverage.~~

(3)~~(4)~~ The inspection required by this section shall be provided by the insurer or by a person or organization authorized by the insurer. The applicant may be required to pay the cost of the inspection, not to exceed $5. The inspection shall be recorded on a form prescribed by the commission, and the form or a copy shall be retained by the insurer with its policy records for the insured. The insurer shall provide a copy of the form to the insured upon request. Any inspection fee paid directly by the applicant may not be considered part of the premium. However, an insurer that provides the inspection at no

cost to the applicant may include the expense of the inspection within a rate filing.

(4)~~(5)~~ The inspection shall include at least the following:

(a) Taking a physical imprint of the vehicle identification number of the vehicle or otherwise recording the vehicle identification number in a manner prescribed by the commission.

(b) Recording the presence of accessories required by the commission to be recorded.

(c) Recording the locations of and a description of existing damage to the vehicle.

(5)~~(6)~~ An insurer may defer an inspection for 30 calendar days following the effective date of coverage for a new policy, but not for a renewal policy, and for additional or replacement vehicles to an existing policy, if an inspection at the time of the request for coverage would create a serious inconvenience for the applicant and such hardship is documented in the insured's policy record.

(6)~~(7)~~ The commission may, by rule, establish such procedures and notice requirements that it finds necessary to implement this section.

(7) Notwithstanding any other provision of this section, an insurer may opt out of the inspection requirements of this section. An insurer opting out of the inspection must file a manual rule with the office indicating that the insurer will not participate in the inspection program under this section. An insurer that files such a manual rule with the office may establish its own preinsurance inspection requirements as a condition to issuing a private passenger motor vehicle insurance policy. The insurer's preinsurance inspection requirements must

be included in the manual rule filed with the office. An insurer opting out of the inspection requirements of this section may not require an applicant to pay for the cost of an inspection.

~~(8) The Division of Insurance Fraud of the Department of Financial Services shall provide a report of data from the required preinsurance inspection of motor vehicles to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2016.~~

~~(a) The data must include, but need not be limited to:~~

~~1. A written estimate of the total cost incurred by insurers and policyholders in order to comply with the inspections.~~

~~2. A written estimate of the total cost incurred by insurers to have their motor vehicles inspected.~~

~~3. Documentation regarding the total premium savings for policyholders as a result of the inspections.~~

~~4. Documentation of the total number of inspected motor vehicles that had a preexisting condition.~~

~~5. Documentation regarding the potential fraud in motor vehicle claims incurred within the first 125 days after issuance of a new policy.~~

~~6. Documentation of the total number of referrals of fraudulent acts to the National Insurance Crime Bureau by preinsurance inspectors during the past 5 years.~~

~~(b) The Legislature may use the report data in determining the future public necessity for this section.~~

Section 12. Effective September 1, 2017, section 641.3915, Florida Statutes, is amended to read:

641.3915 Health maintenance organization anti-fraud plans

and investigative units.—Each authorized health maintenance organization and applicant for a certificate of authority shall comply with the provisions of ss. 626.989 and 626.9891 as though such organization or applicant were an authorized insurer. ~~For purposes of this section, the reference to the year 1996 in s. 626.9891 means the year 2000 and the reference to the year 1995 means the year 1999.~~

Section 13. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.