FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

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BILL #: CS/HB 881	**COMPANION BILL:** SB 1428 (DiCegile)
TITLE: Insurance	**LINKED BILLS:** None
SPONSOR(S): Griffitts	**RELATED BILLS:** None

Committee References

Insurance & Banking
17 Y, 1 N, As CS
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Commerce

SUMMARY

Effect of the Bill:

The bill:

- Defines "sufficient evidence" for precluding bad faith actions against liability insurers.
- Authorizes the Florida Department of Law Enforcement (FDLE) to process background checks for insurance personnel.
- Requires fair, documented affiliate compensation; mandates fee-for-service model by July 2026; requires the Office of Insurance Regulation (OIR) approval for payments, dividends, and capital transfers to affiliates.
- Requires all affiliate payments to comply with new standards.
- Requires public adjusters to respond to claim status requests within 14 days.
- Requires annual reports and disclosures for policyowners.
- Updates definitions, surplus and bond requirements for reciprocal insurers; regulates subscriber contributions, savings accounts, and distributions.
- Requires independent subscriber committees with election and oversight duties.
- Repeals outdated provisions; updates merger/conversion procedures.
- Requires reciprocal insurers to maintain unearned premium reserves.

Fiscal or Economic Impact:

The bill will have an indeterminate fiscal impact.

JUMP TO SUMMARY ANALYSIS RELEVANT INFORMATION BILL HISTORY

ANALYSIS

EFFECT OF THE BILL:

Bad Faith

The bill defines "sufficient evidence" for the purpose of precluding bad faith actions against liability insurers. "Sufficient evidence" must include written or photographic evidence of personal or property injury, such as accident reports, photos, medical or repair bills, or receipts. If an insurer believes the evidence is insufficient, it must object in writing within 10 business days or waive the objection. The claimant then has 10 business days to clarify or provide more evidence. This change clarifies what constitutes "sufficient evidence" necessary to trigger the start of the time period within which the insurer must tender payment to avoid bad faith. (Section 1).

Background Checks

The bill authorizes the FDLE to accept and process fingerprints and exchange criminal history records for individuals involved in the insurance industry. The bill requires background checks for a wide range of persons associated with insurers or insurance-related entities, including organizers, officers, employees, contractors, and others who may influence or control insurance operations. Fingerprints must be submitted to the OIR or an authorized vendor and will be processed by both the FDLE and the Federal Bureau of Investigation. The results of the background checks will be used by the OIR to determine whether individuals meet eligibility requirements for

licensure, certification, or authority to operate under the Florida Insurance Code. The bill also provides procedures for submission, retention, and cost responsibilities associated with fingerprint processing and background checks. (Section 2).

Affiliate Transaction Oversight

The bill provides increased regulatory oversight of financial transactions between insurers and affiliated entities, including managing general agents (MGAs), attorneys in fact, and reciprocal insurers. The bill applies to any insurer that contracts with or makes payments to such entities and establishes requirements to ensure those payments are fair, reasonable, and in the insurer's best interest.

The bill defines key terms, including "affiliated entity," which broadly includes affiliates, MGAs, attorneys in fact, and reciprocal insurers involved in compensation or contractual arrangements with the insurer.

The bill requires insurers to submit documentation to the OIR demonstrating that all fees, commissions, or payments to affiliated entities are fair and reasonable for each service provided. The OIR must evaluate this using specified factors, including the actual cost of services, financial condition of the parties, debt levels, dividends or payments exchanged, and whether the contract terms benefit the insurer.

For all agreements in effect on July 1, 2025, insurers must report by October 1, 2025, the costs incurred by affiliates, amounts charged to the insurer, and any fees forgiven or reimbursed over the past two years. If charges exceed costs, insurers must justify how the fees are fair and reasonable. New contracts after that date must include similar documentation before becoming effective.

Beginning July 1, 2026, all compensation arrangements must follow a fee-for-service model, meaning fixed or hourly rates for itemized services. Compensation may not be based on commissions, premium volume, underwriting profits, or financial performance of the insurer. Dividends or other financial arrangements with affiliates are still allowed but must be separately reviewed and approved by the OIR.

The bill also provides that:

- All agreements with affiliated entities must include a termination clause and may not exceed three years without undergoing review and reapproval by the OIR.
- The OIR must be notified at least 30 days in advance before an insurer pledges capital or assets to an affiliate, and the OIR may prohibit such arrangements if not in the insurer's best interest.
- During a declared emergency, the OIR may issue orders restricting transfers of funds to affiliates without prior approval, for up to 90 days, with extensions allowed.
- All dividends paid to affiliates, regardless of relationship, must be approved by the OIR.
- The OIR may recover improper transfers, including those made in violation of approved arrangements or while the insurer was undercapitalized.

Finally, the bill authorizes the OIR to impose penalties for violations of these requirements and requires the Financial Services Commission to adopt rules to implement these provisions. (Section 3).

Application of Dividend Requirements to Affiliated Entities

The bill expands dividend restrictions and requirements currently applicable to domestic stock insurers to include application to affiliated entities. Additionally, the bill requires that any approval of a dividend, distribution, or other financial arrangement comply with the affiliate transaction oversight provisions created in the bill. (Section 7).

Authority Over Affiliate Dividends

The bill gives the OIR express oversight and regulatory authority over dividends and other financial arrangements paid to affiliates. The bill prohibits the declaration or distribution of such payments without prior approval from the OIR. It also requires that all affiliate dividends and financial arrangements comply with the affiliate transaction oversight provisions created in the bill. The bill authorizes the OIR to impose penalties for unauthorized transactions and directs the OIR to adopt rules to implement the section. (Section 8).

Affiliate Compensation Compliance
The bill requires that affiliate compensation arrangements comply with the provisions created in the bill, in addition, to the existing requirement that such payments be fair and reasonable. (Section 4).

Reciprocal affiliates
The bill specifies that the attorney in fact of a reciprocal insurer is considered an affiliated entity of the reciprocal for purposes of section 624.10, F.S., and the affiliated entity provisions created in the bill apply to reciprocal affiliates. (Section 11).

Public Adjusters

The bill requires public adjusters to respond to claim status requests within 14 days. (Section 5).

Universal Life Insurance Policies

The bill establishes annual reporting requirements and policy disclosures for universal life insurance policies issued in Florida. It defines key terms such as "universal life insurance policy[1]," "policy value[2]," "net cash surrender value[3]," and distinguishes between fixed-premium[4] and flexible-premium policies.[5]

The bill requires insurers to provide policyowners with a free, annual status report that includes specific information such as policy values, credited and debited amounts, outstanding loans, current death benefits, and net cash surrender value. The report must also include warnings when the policy's value is projected to be insufficient to keep the policy in force, either until the next reporting period or until contract maturity, depending on the type of policy.

These requirements apply to all universal life insurance policies issued in the state, excluding variable contracts as defined in s. 627.8015, F.S. (Section 6).

Reciprocal Insurers

The bill modifies the definition of a reciprocal insurer to include two new classes: assessable reciprocal insurers and non-assessable reciprocal insurers. (Section 9).

Assessable and Non-Assessable Reciprocal Insurers
The bill amends the surplus funds required for a reciprocal insurer, with such requirements differing based on whether the reciprocal is assessable or non-assessable. Current law requires reciprocal insurers to have $750,000 in expendable surplus when first authorized, and to maintain $250,000 in surplus funds. Under the bill:

- Assessable reciprocal insurers must have and maintain surplus funds of at least $3 million to transact insurance.
- Non-assessable reciprocal insurers are subject to the surplus required under 624.408, F.S., for a domestic stock insurer authorized to transact like kinds of insurance. (Section 10).

Attorney in Fact Bond
The bill increases the bond amount required for an attorney in fact of a domestic reciprocal insurer from $100,000 to $300,000 and clarifies that the bond must be in favor of the state for the benefit of all persons damaged by a breach of the bond conditions. (Section 12).

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[1] Universal life insurance policy means any individual life insurance policy, rider, group master policy, or individual certificate, under the provisions of which separately identified interest credits and mortality and expense charges are made to the policy. The policy, rider, or certificate does not apply to policies, riders, group master policies, or individual certificates in connection with dividend accumulations, premium deposit funds, or other supplementary accounts. A universal life insurance policy may provide for other credits and charges, such as charges for the cost of benefits provided by a rider.
[2] Policy value means the value of any individual life insurance policy, rider, group master policy, or individual certificate, under the provisions of which separately identified interest credits, other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts, and mortality and expense charges are made to the policy. A universal life insurance policy may provide for other credits and charges, such as charges for the cost of benefits provided by a rider.
[3] Net cash surrender value means the maximum amount payable to the policyowner upon surrender.
[4] Fixed-premium universal life insurance policy means a universal life insurance policy other than a flexible-premium universal life insurance policy.
[5] Flexible-premium universal life insurance policy means a universal life insurance policy that allows the policyowner to vary, independently of each other, the amount of timing of one or more premium payments or the amount of insurance.

Subscriber Advisory Committee
The bill revises the structure and governance requirements for subscribers' advisory committees[6] of reciprocal insurers. It requires each reciprocal insurer to establish a subscribers' advisory committee that represents the interests of its subscribers, with governing rules and any amendments subject to approval by the OIR.

The bill expands the committee's duties to include supervising the insurer's operations for compliance with all governing documents and authorizes the committee to hire independent professionals at the insurer's expense. The initial committee must be appointed by the original subscribers or the attorney in fact.

At least two-thirds of the committee must be independent subscribers who are not affiliated with the attorney in fact. These members must be elected by the subscribers within six months of the insurer receiving its certificate of authority. The bill also requires reciprocal insurers with more than 50 subscribers to provide a platform that enables subscribers to communicate with one another about the election process. (Section 17).

Subscriber Contributions
The bill authorizes reciprocal insurers to require subscriber contributions[7] in addition to premiums, subject to prior approval by the OIR. The bill requires reciprocal insurers to clearly disclose such contributions on the declarations page of the policy and to provide subscribers with an annual report detailing how each dollar of the contribution was allocated or spent. (Section 13).

Subscriber contributions may not exceed 2 percent of each individual subscribers' policy premium for a nonassessable reciprocal insurer and 10 percent of each individual subscribers' policy premium for an assessable reciprocal insurer. Subscriber contributions are allowed as assets for the purposes of determining the reciprocal's financial condition, except that any premium deposits delinquent for 90 days will first be charged against such subscriber contributions. (Section 18).

Subscriber Savings Accounts
The bill authorizes reciprocal insurers to establish subscriber savings accounts[8] and sets requirements for their use and disclosure. The bill requires insurers to inform subscribers in writing about limitations, restrictions, distribution procedures, and calculation methods. Additionally, the bill requires that advertisements disclose limitations and provides that, upon policy cancellation or nonrenewal, subscribers are entitled to the funds in their accounts unless otherwise restricted by law, contract, or regulatory order. (Section 14).

Subscriber Distributions
The bill authorizes to make distributions[9] to subscribers from their subscriber savings accounts. The subscribers' advisory committee shall have sole authority to authorize distributions, subject to prior the OIR approval. Any reciprocal that otherwise authorizes distributions but prohibits subscribers from receiving distributions for a specified period of time, including after initial subscription, must renew the subscriber's policy for that period of time plus 1 additional policy year. This does not prohibit the cancellation or nonrenewal of a policy pursuant to 624.4133, F.S., or by the OIR order.

The bill provides that a reciprocal insurer may return to its subscribers any unused premiums, savings, or credits accruing to their accounts. Such distribution may not unfairly discriminate between classes of risks or policies, or between subscribers, but may vary as to classes of subscribers based on the experience of the classes.

[6] Subscribers' advisory committee means the committee of a domestic reciprocal insurer which is formed in compliance with s. 629.201 and represents the interests of the subscribers.
[7] Subscriber contribution means any transfer of money by a subscriber of a reciprocal insurer to the reciprocal insurer in excess of the premium approved by the office, when such money is counted as surplus for the reciprocal insurer or used to pay surplus notes.
[8] Subscriber savings account means any account in which a reciprocal insurer assigns money for the benefit of an individual subscriber, other than accounts holding money for the payment of a specific claim by or settlement of a specific legal dispute with that individual subscriber.
[9] Distribution means any transfer of money from the reciprocal insurer to subscribers other than for the payment of a claim, settlement of a legal dispute, or return of principle.

The bill provides that a domestic reciprocal insurer may, upon prior written OIR approval, pay to its subscribers a portion of unassigned funds of up to 10 percent of surplus, with distribution limited to 50 percent of net income from the previous calendar year. Such distribution may not unfairly discriminate between classes of risks or policies, or between subscribers, but may vary as to classes of subscribers based on the experience of the classes. (Section 15).

Annual Statement
The bill specifies that the annual statement procured by the subscribers advisory committee must be an audited annual statement of the accounts and records of the insurer and the attorney in fact. The bill provides that:

- The insurer's statement must be prepared by an independent auditor at the insurer's expense, and made available for inspection by any subscriber, and filed by the attorney in fact.
- The statement of the attorney in fact must be prepared by an independent auditor at the expense of the attorney in fact, and filed with the annual statement of the reciprocal. (Section 16).

Repealed Provisions Related to Reciprocal Insurers
The bill repeals several provisions of ch. 629, F.S., relating to reciprocal insurers, including

- 629.271, F.S. This section is effectively replaced by the bill's subscriber distributions provision. (Section 19).
- 629.401, F.S. Removes a cross reference to a repealed statute. (Section 22 and 25).
- 629.520, F.S. (Section 23).

Merger or Conversion
The bill makes two technical changes regarding reciprocal insurers merger or conversion.

- The Financial Services Commission, rather than the OIR, will provide the appropriate legal forms for merging reciprocals or conversion into a stock or mutual insurer.
- Clarifies language in statute to make it clearer that the provision is applicable in the case of either merger or conversion. (Section 20).

Impaired Reciprocal Insurers
The bill clarifies that the OIR issues the order for the attorney in fact to make up a deficiency or levy an assessment and specifies that, upon liquidation, the receiver shall levy assessments on subscribers to cover all liabilities, including liquidation costs, subject to any limits in the power of attorney, the policy, or ch. 629, F.S. (Section 21).

Unearned Premium Reserve
The bill creates s. 629.56, F.S., to require reciprocal insurers to maintain an unearned premium reserve at all times in accordance with section 625.051, F.S. (Section 24)

Compliance Deadlines for Existing Reciprocal Insurers
The bill provides that reciprocal insurers licensed before July 1, 2025, must comply with the new subscribers' advisory committee requirements in s. 629.201, F.S., by July 1, 2026, and with the new unearned premium reserve requirements in s. 629.56, F.S., by July 1, 2027. (Section 26).

Except as expressly provided otherwise, the bill takes effect July 1, 2025. (Section 27).

RULEMAKING:

The bill grants rulemaking authority to the OIR to implement the affiliate transaction oversight provisions created by the bill, and requires rulemaking to implement s. 628.372, F.S., relating to dividends and financial arrangements with affiliates.

Lawmaking is a legislative power; however, the Legislature may delegate a portion of such power to executive branch agencies to create rules that have the force of law. To exercise this delegated power, an agency must have a grant of rulemaking authority and a law to implement.

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

The bill will have an indeterminate fiscal impact.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida.[10] As part of their regulatory oversight, the OIR may suspend or revoke an insurer's certificate of authority under certain conditions.[11] The OIR is responsible for examining the affairs, transactions, accounts, records, and assets of each insurer that holds a certificate of authority to transact insurance business in Florida.[12] As part of the examination process, all persons being examined must make available to the OIR the accounts, records, documents, files, information, assets, and matters in their possession or control that relate to the subject of the examination.[13] The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code.[14]

Insurance companies that transact insurance in Florida or that have offices located in the state are required to obtain a certificate of authority (COA) issued by the OIR pursuant to s. 624.401, F.S. These companies, referred to as authorized or admitted insurers,[15] are broadly regulated by the OIR under the Insurance Code as to reserves, surplus as to policyholders, solvency, rates and forms, market conduct, permissible investments, and affiliate relationships.[16] Authorized insurers are also required to participate in a variety of government mandated insurance programs and pay assessments levied by state guaranty funds in the event of insurer insolvencies.[17]

Bad Faith in Insurance

Insurance is a contract between an insurance company ("insurer") and the insurance policy's beneficiary ("the insured"), in which, for specified consideration called a "premium," the insurer agrees to pay the insured or third-party claimants for covered losses.[18] An insurer generally owes two significant contractual duties to its insured in exchange for premium payments: the duty to indemnify and the duty to defend.[19]

- The "duty to indemnify" refers to the insurer's obligation to issue payment to the insured on a valid claim.[20] For example, an insured may purchase a policy requiring the insurer to replace the insured's vehicle in the event of a car accident. If a covered accident then occurs, causing the insured's vehicle to be destroyed, the duty to indemnify requires the insurer to replace the insured's vehicle.
- The "duty to defend" refers to the insurer's duty to defend the insured in court against a third party with respect to a covered claim.[21] For example, an insured may purchase a liability policy in the event the insured causes a car accident and injuries a third party. If a covered accident then occurs, causing injury to

[10] s. 20.121(3)(a), F.S. The Financial Services Commission, composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, serves as agency head of the Office of Insurance Regulation for purposes of rulemaking. Further, the Financial Services Commission appoints the commissioner of the Office of Insurance Regulation.
[11] s. 624.418, F.S.
[12] s. 624.316(1)(a), F.S.
[13] s. 624.318(2), F.S.
[14] s. 624.3161, F.S.
[15] An "authorized" or "admitted" insurer is one duly authorized by a COA to transact insurance in this state.
[16] The Insurance Code consists of chs. 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S.
[17] For example, Florida licensed direct writers of property and casualty insurance must be members of the Florida Insurance Guaranty Association, which handles the claims of insolvent insurers under part II of ch. 631, F.S., and insurers offering workers' compensation coverage in Florida must be members of the Florida Workers' Compensation Insurance Guaranty Association, which provides payment of covered clander part V of ch. 631, F.S.
[18] 16 Williston on Contracts s. 49:103 (4th ed.).
[19] *Id.*
[20] *Id.*
[21] *Id.*

a third-party claimant who sues the insured, the duty to defend requires the insurer to defend the insured against the claimant's lawsuit.

Insurer's Common Law and Statutory Duties
Florida courts, in applying the common law, recognize that an insurer owes its insured a duty of good faith in negotiating settlements with third-party claimants.[22] There is also a statutory duty of good faith codified in s. 624.155, F.S. Under that provision, a statutory bad faith claim may arise where the insurer:

- Does not attempt in good faith to settle claims when, under all the circumstances, it could and should have done so;
- Makes claim payments without a statement identifying the applicable coverage; or
- Fails to promptly settle a claim under one portion of the policy to influence settlement under another portion.

Florida courts have interpreted an insurer's obligation to "act fairly" towards its insured, holding that when the insured's liability is clear and an excess judgment[23] is likely due to the resulting damage, the insurer has an affirmative duty to initiate settlement negotiations with third-party claimants.[24] If settlement fails, the insurer has the burden of showing that there was no realistic possibility of settling the claim within the policy limits.[25]

However, failure to settle a claim, without more, does not necessarily mean that an insurer has acted in bad faith, as liability may be unclear or the damages may be minimal. Further, courts have generally indicated that merely negligently failing to settle a claim does not rise to the level of bad faith, though a jury may consider negligence in the larger context of whether bad faith occurred.[26]

First-Party vs. Third-Party Bad Faith Claims
There are two general types of bad faith claims: "first-party" claims and "third-party" claims.

- A "first-party" bad faith claim is a claim filed by the insured against his or her own insurer; these claims typically involve allegations that the insurer improperly denied the insured coverage under the policy, underpaid a covered claim, or delayed payment without adequate justification.[27]
- A "third-party" bad faith claim arises when the insured is exposed to liability to a third party; such a claim, which may be brought by either the insured or the third party, typically arises when:
    - An insurer fails to settle in good faith a third party's claim against the insured within the policy limits;
    - There is serious injury to the third-party claimant; and
    - The policy limits are minimal, thus exposing the insured to an excess judgment.[28]

Legislative Reforms – HB 837 (2023)
In 2023, HB 837 amended s. 624.155, F.S., to clarify that mere negligence is not sufficient to constitute bad faith and established that the insured, third-party claimant, and any representative of either have a duty to act in good faith when furnishing claim information, making demands, setting deadlines, or attempting to settle.[29] The judge or jury (trier of fact) may consider a failure to act in good faith by any of these parties and may reasonably reduce damages awarded against the insurer accordingly.[30]

Additionally, HB 837 established a safe harbor from bad faith liability in liability insurance claims. An insurer is not liable for bad faith under either statute or common law if it tenders the lesser of the policy limits or the amount

[22] *Mut. Indemnity Co. v. Shaw,* 184 So. 852 (Fla. 1938).
[23] An "excess judgment" is a judgment in an amount over and above the insurance policy's coverage limits, which amount is paid out of the insured's own pocket.
[24] *Powell v. Prudential Prop. and Cas. Ins. Co.*, 584 So. 2d 12, 14 (Fla. 3d DCA 1991).
[25] *Id.* at 14.
[26] *See DeLaune v. Liberty Mut. Ins. Co.*, 314 So. 2d 601, 603 (Fla. 4th DCA 1975).
[27] The Florida Senate, *Interim Report 2012-132: Insurance Bad Faith* (Nov. 2011), https://www.flsenate.gov/publishedcontent/session/2012/interimreports/2012-132ju.pdf (last visited March. 24, 2025).
[28] *Id.*
[29] ch. 2023-15, Laws of Fla.
[30] *Id*.

demanded by the claimant within 90 days after receiving actual notice of the claim along with sufficient evidence to support the amount. If the insurer does not tender within the 90-day period, the following applies:

- The existence of the safe harbor period and the fact that no bad faith action would have accrued had payment been tendered are inadmissible in a subsequent bad faith action; and
- The applicable statute of limitations is extended by 90 days.[31]

HB 837 further provided that if multiple third-party claimants present competing claims arising out of a single occurrence that may exceed the insured's policy limits, the insurer is not liable beyond those limits if, within 90 days, it either:

- Files a lawsuit (interpleader action) under the Florida Rules of Civil Procedure; or
- Agrees to binding arbitration and makes the full policy limits available for distribution before a mutually selected arbitrator, at the insurer's expense.[32]

Bad Faith Claim Pre-Suit Notice Requirement

To bring a statutory bad faith claim under s. 624.155, F.S., whether first-party or third-party, a plaintiff must first give the insurer 60 days' written notice of the claim by filing a civil remedy notice with Department of Financial Services (DFS).[33] The insurer then has 60 days from receiving notice from DFS to either pay the damages or correct the circumstances giving rise to the bad faith claim, and the statutory cause of action does not accrue until the 60-day "cure" period has run without the insurer taking such steps.[34] Where the insurer timely pays the damages or otherwise corrects the circumstances giving rise to the bad faith claim, no statutory bad faith lawsuit may be brought.[35]

If a plaintiff brings a third-party common law bad faith claim, by contrast, there is no statutory pre-suit notice requirement; thus, the insurer cannot avoid a third-party bad faith lawsuit by paying the damages or curing the circumstances giving rise to the claim within the statutory cure period. However, after HB 837 (2023), the claimant now has the right to offer the insurer an opportunity to cure.

Filing a Bad Faith Claim

Generally, a bad faith cause of action does not accrue until the underlying contractual claim is resolved.[36] In a first-party context, this means the insured must prevail on their coverage claim before bringing a bad faith suit. In a third-party context, the action usually accrues only after an excess judgment is entered against the insured.[37]

Indefiniteness About What Constitutes Bad Faith

Florida law does not precisely define "bad faith," and the determination is generally a question of fact for the jury, based on the totality of the circumstances.[38] Courts have noted that insurer liability must be based on more than a failure to settle or negligence—there must be conduct showing a lack of fair dealing or failure to give due regard to the insured's interests.[39]

Florida Department of Law Enforcement

The Florida Department of Law Enforcement (FDLE) is a state agency created in 1969 to provide investigative, forensic, and criminal justice services in support of Florida's law enforcement community.[40] FDLE operates under the direction of the Florida Cabinet and maintains its headquarters in Tallahassee, with regional operations

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[31] *Id.*
[32] ch. 2023-15, Laws of Fla.
[33] s. 624.155(3)(a), F.S.
[34] s. 624.155(3)(c), F.S.; *Talat Enterprises, Inc. v. Aetna Cas. & Sur. Co.,* 753 So. 2d 1278, 1284 (Fla. 2000).
[35] s. 624.155(3)(c), F.S.
[36] *Blanchard v. State Farm Mut. Auto. Ins. Co.*, 575 So. 2d 1289, 1291 (Fla. 1991).
[37] *Id.*
[38] *Berges v. Infinity Ins. Co.*, 896 So. 2d 665 (Fla. 2004).
[39] *See* DeLaune v. Liberty Mut. Ins. Co., 314 So. 2d 601, 603 (Fla. 4th DCA 1975) (holding that negligence alone does not amount to bad faith); *Macola v. Gov't Emps. Ins. Co.*, 953 So. 2d 451, 458 (Fla. 2007) (explaining that payment of policy limits after a civil remedy notice does not bar a common law bad faith claim); *Blanchard v. State Farm Mut. Auto. Ins. Co.*, 575 So. 2d 1289, 1291 (Fla. 1991) (bad faith action does not accrue until coverage and damages are determined); *Berges v. Infinity Ins. Co.*, 896 So. 2d 665, 680 (Fla. 2004) (bad faith is assessed under the totality of the circumstances and requires fair and honest treatment of the insured's interests).
[40] s. 943.03, F.S.

throughout the state. FDLE's mission is to promote public safety and strengthen domestic security by providing services to local, state, and federal agencies.[41]

FDLE is responsible for processing criminal history background checks and fingerprint submissions for a wide range of professions and regulatory programs, including those involving licensure and employment eligibility.[42] The agency is authorized to exchange fingerprint data with the United States Department of Justice as part of national criminal history checks.[43]

As part of Florida's oversight of the insurance industry, the FDLE provides access to criminal history information to noncriminal justice agencies, such as the Department of Financial Services (DFS), for use in evaluating insurance licensure applications.[44] Individuals applying for licenses—such as insurance agents, adjusters, and other regulated professionals—must submit to fingerprint-based background screenings.[45] Fingerprints must be submitted electronically through a LiveScan vendor approved by FDLE.[46] FDLE processes the fingerprints and transmits the results to the appropriate licensing authority, typically DFS, to determine the applicant's eligibility.[47]

Division of Insurance Agent and Agency Services

The DFS Division of Insurance Agent and Agency Services is responsible for the licensing and regulation of insurance agents, adjusters, insurance agencies, as well as related personnel and business entities.[48]

No person may be, act as, or advertise, or hold himself/herself out to be an insurance agent, insurance adjuster, or customer representative unless he or she is currently licensed by DFS and appointed by an appropriate appointing entity or person.[49] There are several types of insurance representatives. These include:

- General lines agents,
- Life insurance agents,
- Health insurance agents,
- Title insurance agents,
- Personal lines agents,
- Unaffiliated insurance agents, and
- Managing general agents.[50]

Life Insurance

Part III of chapter 627, Florida Statutes, governs life insurance and annuity contracts.[51] "Life insurance" refers to insurance on human lives and includes the issuance of annuity contracts.
Life insurance may:

- Provide a death benefit to an individual's beneficiaries;
- Allow survivors to pay off debts and other expenses; and
- Serve as a source of income to replace earnings lost due to the insured's death.[52]

There are two primary types of life insurance:

- Term life insurance, which provides coverage for a specified period and is generally less expensive; and
- Permanent life insurance, which provides lifelong coverage and may build cash value over time. Variations of permanent life insurance include universal life insurance, which is commonly marketed by life insurance companies and includes a savings component.[53]

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[41] FDLE, *Mission Statement*, https://www.fdle.state.fl.us (last visited April 1, 2025).
[42] S. 943.053, F.S.
[43] S. 943.054, F.S.
[44] S. 943.053(3)(a), F.S.
[45] S. 626.171(4), F.S.
[46] Florida Department of Financial Services, *Fingerprinting Information*, https://www.myfloridacfo.com/division/agents/licensing/agents-and-adjusters/fingerprinting-information. (last visited on April 2, 2025).
[47] *Id.*
[48] Ch. 626, parts I, II, III, IV, V, VI, VIII, IX, and XIII, F.S.
[49] S. 626.112, F.S.
[50] S. 626.015, F.S.
[51] S. 624.602(1), F.S.
[52] Florida Office of Insurance Regulation, *Life Insurance*, https://flOIR_.com/life-health/life (last visited April 1, 2025).
[53] *Id.*

Universal Life Insurance

Universal life insurance is a type of permanent life insurance that offers lifetime coverage as long as premiums are paid.[54] It includes a cash value component and allows policyholders to adjust the amount and timing of premium payments and the death benefit, subject to policy terms and tax law limitations.[55]

Policyholders may choose between interest-sensitive policies and those with guaranteed interest rates. Interest-sensitive policies allow policyholders to accept some investment risk in exchange for the possibility of higher returns. If the cash value becomes underfunded, the policyholder may need to make increased premium payments to maintain coverage.[56]

Universal life insurance can be used to meet evolving financial obligations, such as those related to marriage, raising a family, or estate planning.[57]

Managing General Agents

Some insurers operate within a holding company system that includes a managing general agent (MGA).[58] An MGA is a specialized type of insurance agent or broker that has underwriting authority from an insurer.[59] MGAs can perform certain functions that insurers typically handle, including binding coverage, underwriting and pricing, agent appointments, and claims adjusting and settlement.[60] An MGA may be an affiliate of an insurer. Section 624.10(1), F.S., defines an affiliate as an entity that exercises control over or is directly or indirectly controlled by an insurer. MGAs must enter into contracts with the insurers they do business with, including those that are affiliates—that is, entities that control or are controlled by the insurer.[61] These contracts must specify the division of responsibilities between the insurer and the MGA.[62]

There is currently no statutory limit on the duration of these contracts.

Examination of Insurers and MGAs

The OIR is responsible for examining the affairs, transactions, accounts, records, and assets of each insurer that holds a certificate of authority to transact insurance business in Florida.[63] The OIR's examination authority extends to MGAs.[64]

As part of the examination process, all persons being examined must make available to the OIR the accounts, records, documents, files, information, assets, and matters in their possession or control that relate to the subject of the examination.[65] As part of an examination, the OIR reviews contracts between insurers and MGAs, so that it can determine how much an insurer is paying its MGA and what services the insurer is receiving for the fee it pays. The scope of the examination of an insurer's affiliates in a holding company system is limited to information reasonably necessary to ascertain an insurer's financial condition.

Reciprocal Insurers

Reciprocal insurance exchanges are a form of insurance organization in which businesses and individuals exchange insurance contracts and spread the risks associated with such contracts among themselves.[66] Policyholders of a

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[54] https://www.investopedia.com/terms/u/universallife (last visited April 1, 2025).
[55] *Id.*
[56] S. 627.6562(1), F.S.
[57] *Id.*
[58] *See* s. 628.801, F.S. An "insurance holding company system" consists of two or more affiliated persons, one or more of which is an insurer.
[59] S. S. 626.015(16)(a), F.S., *see also*, International Risk Management Institute, https://www.irmi.com/term/insurance-definitions/managing-general-agent (last visited Mar. 28, 2025);
[60] *Id.*
[61] S. 626.7451, F.S.
[62] *Id.*
[63] s. 624.316(1)(a), F.S.
[64] *Id.;* S. 626.7452, F.S.
[65] s. 624.318(2), F.S.
[66] Julia Kagan and Eric Estevez, *Reciprocal Insurance Exchange: Definition, How It Works, Example* (last updated Sep. 28, 2023), Investopedia, https://www.investopedia.com/terms/r/reciprocal-insurance-exchange.asp (last visited Mar. 28, 2024).

reciprocal insurance exchange are known as "subscribers."[67] A reciprocal insurer operates through a common representative known as the attorney in fact, who manages the day-to-day business and executes insurance contracts on behalf of all subscribers.[68] The authority of the attorney in fact is granted through a power of attorney agreement signed by each subscriber.[69]

Chapter 629, Florida Statutes, governs the regulation of reciprocal insurers in Florida. A reciprocal insurer may transact any type of insurance authorized under the Florida Insurance Code, except title insurance. Reciprocal insurers must be licensed by the OIR and are subject to financial and operational requirements, including annual reporting and minimum surplus standards.[70]

Reciprocal insurers are required to maintain an unearned premium reserve. This reserve represents the unearned portion of gross premiums on in-force policies and must be calculated using a method approved by the OIR. [71]

Reciprocal insurers are subject to surplus requirements based on their structure.[72] Assessable reciprocal insurers must maintain a minimum surplus of $250,000. Nonassessable reciprocals are required to maintain the same surplus as domestic stock insurers and, when first authorized, must also hold an expendable surplus of at least $750,000.[73]

Typically, an advisory board manages a reciprocal insurance company.[74] The board is responsible for choosing and monitoring the attorney-in-fact, approving rates, and providing oversight of the operations of the reciprocal.[75]

Reciprocal insurers are also governed by a subscribers' advisory committee**,** which represents the interests of the subscribers and is responsible for oversight of the attorney in fact and insurer operations. The advisory committee must be selected under rules adopted by the subscribers and approved by the OIR.[76] Not less than two-thirds of the committee must consist of subscribers who are not the attorney in fact or any person employed by, representing, or having a financial interest in the attorney in fact.[77] The committee must:

- Supervise the finances of the insurer;
- Supervise the insurer's operations to such extent as to assure conformity with the subscribers' agreement and power of attorney;
- Procure the audit of the accounts and records of the insurer and of the attorney at the expense of the insurer; and
- Have such additional powers and functions as may be conferred by the subscribers' agreement.[78]

Impaired Reciprocal Insurers

If a reciprocal insurer becomes impaired—meaning it is unable to meet its obligations or maintain required surplus—the Department of Financial Services may initiate rehabilitation or liquidation proceedings under ch. 631, F.S., including potential rehabilitation under s. 631.051, F.S.**,** or liquidation under s. 631.061, F.S. [79]

Mergers Involving Reciprocal Insurers

Reciprocal insurers may merge or consolidate under Part III of Chapter 628, F.S.**,** with approval from the Office of Insurance Regulation. The unique governance structure of reciprocals, including the attorney in fact and subscribers' advisory committee, must be considered in any proposed transaction.[80]

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[67] *Id.*
[68] Verstein, *supra* note 4 at 264.
[69] *Id.* at 251.
[70] S. 629.041(1), F.S. Such an insurer may purchase reinsurance and may grant reinsurance as to any kind of insurance it is authorized to transact directly. *See* s. 629.041(2), F.S.
[71] s. 625.051, F.S.
[72] S. 629.071, F.S.
[73] *Id.*
[74] S. 629.041(1), F.S. Such an insurer may purchase reinsurance and may grant reinsurance as to any kind of insurance it is authorized to transact directly. *See* s. 629.041(2), F.S.
[75] *Id.*
[76] s. 629.201(1), F.S.
[77] s. 629.201(2), F.S.
[78] s. 629.201(3), F.S.
[79] s. 629.301, F.S.

Payments to Affiliates

Each insurer doing business in Florida that pays a fee, commission, or other financial consideration or payment to any affiliate is required to provide, upon request of the OIR, any information the OIR deems necessary. The fee, commission, or other financial consideration or payment to any affiliate must be fair and reasonable. In determining whether the fee, commission, or other financial consideration or payment is fair and reasonable, the OIR must consider, among other things, the actual cost of the service being provided.[81]

Public Adjusters

Florida law defines a public adjuster as someone who, for something of value, directly or indirectly, prepares, completes, or files an insurance claim for an insured or third-party claimant, or who, for something of value, acts on behalf of, or aids, an insured or third-party claimant in settling a claim for loss or damage covered by an insurance contract, or who advertises for employment as an adjuster of such claims.[82] In general, a claimant executes a contract for the public adjuster to provide claims adjusting services.[83]

Stock vs. Mutual Insurers

In order to transact insurance in this state, the Florida Insurance Code ("Code") states that a certificate of authority is required.[84] To qualify for and hold authority to transact insurance in this state, an insurer must be in compliance with the Code and its charter powers, and must be an incorporated stock insurer, an incorporated mutual insurer, or a reciprocal insurer.

The distinction between stock and mutual insurers is governed by part I, ch. 628, F.S.

- *Stock insurers* are defined as "incorporated insurers with its capital divided into shares and owned by its stockholders," and pay dividends to their stockholders, subject to specified surplus minimums and the OIR's approval.[85]
- *Mutual insurers*, on the other hand, are "incorporated insurers without permanent capital stock, the governing body of which is elected in accordance with this part," and pay dividends to their policyholders, who are members of the insurer.[86]

In other words, stock insurers are investor-owned, while mutual insurers are owned by their policyholders. Mutual insurers may apply to demutualize to become a stock insurer, and stock insurers may apply to convert to a mutual insurer, subject to the OIR's approval.

Dividends to Stockholders

Florida law permits domestic stock insurers to distribute dividends[87] to stockholders under certain conditions. Dividends may only be paid out of available and accumulated surplus funds that are derived from realized net operating profits and realized capital gains.[88]

Without prior approval from OIR, a domestic stock insurer may pay dividends within specific thresholds, such as a percentage of surplus or recent net income. These thresholds include, for example, the lesser of 10 percent of surplus or net gain from operations for life and health insurers, or net income for property and casualty insurers.[89] Certain carryforward provisions may also apply depending on the type of insurer.

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[80] s. 629.111, F.S.
[81] S. 624.424(13), F.S.
[82] s. 626.854, F.S., Public adjusters are regulated under ch. 626, part VI, F.S.
[83] *Id.*
[84] S. 624.401, F.S. The Florida Insurance Code consists of chs. 624, 632, 634, 635, 636, 641, 642, 648, and 651, F.S
[85] Ss. 628.021and 628.371, F.S.
[86] Ss. 628.431 and 628.441, F.S.
[87] A *dividend* is a distribution of a portion of an insurer's accumulated profits or surplus to its shareholders. In the case of a domestic stock insurer, dividends are typically paid in cash and represent a return on the shareholders' investment. Dividends must comply with statutory limitations to ensure that the insurer maintains sufficient surplus to meet its obligations to policyholders and maintain financial stability.
[88] s. 628.371(1), F.S.
[89] s. 628.371(2), F.S.

Alternatively, insurers may pay a dividend without prior approval if the dividend meets specific criteria, such as not exceeding the greater of 10 percent of surplus or the entire net operating profits and realized capital gains from the preceding calendar year. After the dividend is paid, the insurer must retain surplus of at least 115 percent of the minimum required statutory surplus, and it must file notice with OIR at least 10 business days before payment.[90]

The OIR may disapprove any dividend or distribution that exceeds the statutory limits if it determines that the payment would jeopardize the financial condition of the insurer, considering factors such as asset quality, liquidity, premium-to-surplus ratios, and investment income. [91]

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Insurance & Banking Subcommittee	17 Y, 1 N, As CS	4/3/2025	Hamon	Herrera
THE CHANGES ADOPTED BY THE COMMITTEE:	• Adds to the bad faith statute to define "sufficient evidence" and set standards to precluding bad faith actions against liability insurers. • Regulates fees and contracts between insurers and affiliates, moving to fee-for-service models. • Allows regulators to block insurer fund transfers to managing agents during emergencies. • Strengthens oversight of insurer dividends to affiliates. • Overhauls rules for reciprocal insurers, including governance, surplus, and subscriber disclosures. • Requires background checks for key insurance personnel and authorizes FDLE to process fingerprints. • Requires public adjusters to respond to claim status requests within 14 days. • Mandates annual policy status reports for universal life insurance.			
Commerce Committee				

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.

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[90] s. 628.371(3)(b), F.S.
[91] s. 628.371(4), F.S.