Chapter 4 Ethical Requirements

Code Of Ethics

69B-215.050 Receipt of 24 Risks
For purposes of an insurer reporting to the Department agents from whom the insurer received more than 24 risks per calendar year as set forth under Sections 626.752, 626.793, and 626.837, Florida Statutes, the term "received" shall mean the binding of coverage and receipt of payment for such coverage by the insurer to whom the business is submitted by the brokering agent of more than 24 personal lines risks during a calendar year.

69B-215.060 Required Disclosure on Forms
No licensed agent may submit an application to an insurer with which the agent is appointed, or furnish a copy of an application to a prospective insured, unless the name of the insurer is legibly typed or printed on the first page of the application form at the time the coverage is bound or premium is quoted. The application also shall disclose the name and license identification number of the agent as shown on the agent's license issued by the Department, which information shall be legibly typed, printed, stamped, or handwritten. Upon completion of the application, a copy must be provided to the prospective insured.

69B-215.215 Twisting
Twisting is declared to be unethical. No person shall make any misleading representations or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, or convert any insurance policy, or to take out a policy of insurance in another insurer.

69B-215.220 Rebating
Rebating is declared to be unethical. Except as otherwise expressly provided by law, no person shall knowingly permit or offer to make or make any contract of life insurance, life annuity or disability insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or pay or allow, or give or offer to pay, allow, or give, directly or indirectly as an inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract.

69B-215.225 Defamation
Defamation is declared to be unethical and defined as making, publishing or circulating any oral, written or printed statement which is false, or maliciously critical of or derogatory to the financial condition of any insurance company, or which is calculated to injure any person engaged in the business of life insurance, and this practice is declared to be unethical.

69B-215.230 Misrepresentations
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.

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.

69B-215.235 Use of Designations
The purpose of this rule is to set forth standards to protect consumers from dishonest, deceptive, misleading, and fraudulent trade practices with respect to the use of certifications and professional designations in the marketing, solicitation, negotiation, sale or advice made in connection with an insurance transaction by any licensee.

The department does NOT endorse any professional designation.

For purposes of this rule:

-A designation is any combination of words, any acronym standing for a combination of words or any job title that indicates or implies that a licensee has special knowledge or training in advising or servicing consumers beyond the knowledge or training required for the license held.

-A certification is any designation that indicates, implies or recognizes that an individual or organization meets certain established criteria beyond the criteria required for the license held.

-A designation may not be lawfully used under the Insurance Code unless the designation is obtained from an organization that has published standards and procedures for assuring the competency of its certificants or designees on specific subject matters, which standards and procedures are continually utilized by the organization.

-The organization or entity conferring the designation must approve any terminology, combination of words and/or acronym to be used by the designee.

-The prohibited use of any designation includes, but is not limited to, the following:
-Use of a designation by a person who has not actually earned or is otherwise ineligible to use such designation;
-Use of a nonexistent or self-conferred designation;
-Use of a designation that indicates or implies a level of occupational qualifications obtained through education, training, or experience that the person using the designation does not have, and
-Use of any designation not obtained in compliance with subsection (4), above.

Marketing Regulatory And Ethical Guidelines For Florida Licensed Professionals
626.797 Code of ethics
The department shall, after consultation with the Florida Association of Insurance and Financial Advisors, adopt a code of ethics, or continue any such code heretofore so adopted, to govern the conduct of health agents in their relations with the public, other agents, and the insurers.

The code of ethics shall 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 under ss. 626.611 and 626.621 and to avoid the use of unfair trade practices and unfair methods of competition which would be in violation of any provision of part IX.

All applicants for license as health agents shall subscribe to the code of ethics.

Understanding Industry Products & Suitability Sales And Services

69B-151.101 Purpose
The purpose of these rules is to safeguard the interests of persons covered by accident and health insurance policies or plans who are considering replacement of their insurance by making available to them information regarding replacement, thereby reducing the opportunity for misrepresentation or other unfair practices and methods of competition in the business of insurance.

69B-151.102 Scope
These rules apply to the solicitation of accident and health insurance covering residents of this state. They do not apply to the solicitation of the following accident and health insurance:

-Group, blanket or franchise;
-Accident only;
-Single premium nonrenewable;
-Conversion to another individual or family policy issued by the same insurer with continuous coverage;
-Conversion to an individual or family policy from a group, blanket or group type policy; and
-Conversion to a Medicare Supplement policy to replace a basic or major-medical accident and health policy.

69B-151.103 Definitions
As used in these rules:

1. "Replacement" is any transaction wherein new accident and health insurance is to be purchased and it is known to the agent, broker or insurer at the time of application that, as a part of the transaction, existing accident and health insurance has been or is to be lapsed or the benefits thereof substantially reduced.

2. "Direct response insurance" is insurance issued to an applicant who has completed the application and forwarded it directly to the insurer's agent in response to a solicitation coming into the applicant's possession by any means of mass communication.

3. "Continuous coverage" means that the benefits are not less than the benefits under the previous policy, and the policy also covers loss resulting from injury sustained or sickness contracted while coverage was in force under the previous policy to the extent such loss is not covered under any extended benefit or similar provision of the previous policy.

4. As used in this rule chapter the terms "accident and health insurance," "accident and sickness insurance," and "disability insurance" each shall include the others.

69B-151.104 Insurance Application
An application form for insurance subject to these rules shall contain a question to elicit information as to whether the insurance to be issued is to replace any insurance presently in force. If replacement of existing coverage is indicated the application shall state the Company name and policy number. A supplementary application or other form to be signed by the applicant and made a part of the company's file containing such a question may be used.

69B-151.105 Notice Furnished by Forms
(1) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, shall furnish the applicant, upon issuance or delivery of the policy, or prior thereto, the notice described below. Once copy of such notice shall be given to the applicant and an additional copy signed by the applicant shall be retained by the insurer in its home office for at least three years or until the conclusion of the next succeeding regular examination by the Insurance Department of its state of domicile, whichever is later. This notice required for an insurer, other

than a direct response Insurer, shall be provided in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance (insert policy number) you have with (insert Company name) and replace it with a policy to be issued by (insert Company name). For your information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy (to be included if pre-existing conditions are not covered under the replacement policy).

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain that all questions on the application concerning your medical/health history are truthfully and completely answered. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed it should be carefully reviewed before being signed to be certain that all information has been properly recorded.

New policies may be issued at an older age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.

The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.
The above "Notice to Applicant" was delivered to me on:

(date)

Witness (Writing Agent)

(Applicant's Signature)

(2) A direct response insurer shall deliver to the applicant upon issuance of the policy, or within five working days from receipt of the application, whichever date occurs earlier, the notice described below. This notice required for a direct response insurer shall be in a form substantially as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance (insert policy number) you have with (insert Company name) and replace it with the policy delivered herewith issued by (insert Company name). Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert Company Name and Address) within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

(3) An insurer, within five working days from the receipt of an application at its policy issuance office, shall furnish a copy of such notice to the insurer whose policy is being replaced.

69B-151.106 Violation
Any person who violates these rules and by doing so violates any statutory section of Part VII, Chapter 626, F.S., as implemented by these rules, shall be subject to the penalties provided in Section 627.381, F.S., and such other statutory penalties as may be applicable.

Unfair Methods Of Competition And Unfair Or Deceptive Acts
626.951 Declaration of purpose
The purpose of this part is to regulate trade practices relating to the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress (Pub. L. No. 15, 79th Congress), by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
This part shall be entitled the "Unfair Insurance Trade Practices Act."

626.9511 Definitions
When used in this part:

"Person" means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, or business trust or any entity involved in the business of insurance.

"Insurance policy" or "insurance contract" means a written contract of, or a written agreement for or effecting, insurance, or the certificate thereof and includes all clauses, riders, endorsements, and papers which are a part thereof.

626.9521 Unfair methods of competition and unfair or deceptive acts or practices prohibited; penalties
1. No person shall engage in this state in any trade practice which is defined in this part as, or determined pursuant to s. 626.951 or s. 626.9561 to be, an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance.

2. Except as provided in subsection (3), any person who violates any provision of this part is

subject to a fine in an amount not greater than $5,000 for each nonwillful violation and not greater than $40,000 for each willful violation. Fines under this subsection imposed against an insurer may not exceed an aggregate amount of $20,000 for all nonwillful violations arising out of the same action or an aggregate amount of $200,000 for all willful violations arising out of the same action. The fines may be imposed in addition to any other applicable penalty.

3.a. If a person violates s. 626.9541(1)(l), the offense known as "twisting," or violates s.626.9541(1)(aa), the offense known as "churning," the person commits a misdemeanor of the first degree, punishable as provided in s. 775.082, and an administrative fine not greater than $5,000 shall be imposed for each nonwillful violation or an administrative fine not greater than $75,000 shall be imposed for each willful violation. To impose an administrative fine for a willful violation under this paragraph, the practice of "churning" or "twisting" must involve fraudulent conduct.

3.b. If a person violates 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 s. 775.082, and an administrative fine not greater than $5,000 shall be imposed for each nonwillful violation or an administrative fine not greater than $75,000 shall be imposed for each willful violation.

3.c. Administrative fines under this subsection may not exceed an aggregate amount of $50,000 for all nonwillful violations arising out of the same action or an aggregate amount of $250,000 for all willful violations arising out of the same action.

4. A licensee must make all reasonable efforts to ascertain the consumer's age at the time an insurance application is completed.

5. If a consumer who is a senior citizen is a victim, a video deposition of the victim may be used for any purpose in any administrative proceeding conducted pursuant to chapter 120 if all parties are given proper notice of the deposition in accordance with the Florida Rules of Civil Procedure.

26.9541 Unfair methods of competition and unfair or deceptive acts or practices defined
Defamation.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 any 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.

Boycott, coercion, and intimidation.Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in, or tending to result in, unreasonable restraint of, or monopoly in, the business of insurance. False statements and entries.

Knowingly: Filing with any supervisory or other public official, Making, publishing, disseminating, circulating, Delivering to any person, Placing before the public, Causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement.

Knowingly making any false entry of a material fact in any book, report, or statement of any person, or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report, or statement of such person.

Unfair discrimination.

Knowingly making or permitting any unfair discrimination between individuals of the same actuarially supportable class and equal expectation of life, in the rates charged for any life

insurance or annuity contract, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

Knowingly making or permitting any unfair discrimination between individuals of the same actuarially supportable class, as determined at the original time of issuance of the coverage, and essentially the same hazard, in the amount of premium, policy fees, or rates charged for any policy or contract of accident, disability, or health insurance, in the benefits payable thereunder, in any of the terms or conditions of such contract, or in any other manner whatever.

For a health insurer, life insurer, disability insurer, property and casualty insurer, automobile insurer, or managed care provider to underwrite a policy, or refuse to issue, reissue, or renew a policy, refuse to pay a claim, cancel or otherwise terminate a policy, or increase rates based upon the fact that an insured or applicant who is also the proposed insured has made a claim or sought or should have sought medical or psychological treatment in the past for abuse, protection from abuse, or shelter from abuse, or that a claim was caused in the past by, or might occur as a result of, any future assault, battery, or sexual assault by a family or household member upon another family or household member as defined in s. 741.28. A health insurer, life insurer, disability insurer, or managed care provider may refuse to underwrite, issue, or renew a policy based on the applicant's medical condition, but shall not consider whether such condition was caused by an act of abuse.

For purposes of this section, the term "abuse" means the occurrence of one or more of the following acts:

a. Attempting or committing assault, battery, sexual assault, or sexual battery;

b. Placing another in fear of imminent serious bodily injury by physical menace;

c. False imprisonment;

d. Physically or sexually abusing a minor child; or

e. An act of domestic violence as defined in s. 741.28.

f. Unfair claim settlement practices.

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;

2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy; or

3. Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Failing to adopt and implement standards for the proper investigation of claims;

b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

c. Failing to acknowledge and act promptly upon communications with respect to claims;

d. Denying claims without conducting reasonable investigations based upon available information;

e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed;

f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;

g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or

h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

i. Failing to pay personal injury protection insurance claims within the time periods required by s.627.736(4)(b). The office may order the insurer to pay restitution to a policyholder, medical provider, or other claimant, including interest at a rate consistent with the amount set forth in s. 55.03(1), for the time period within which an insurer fails to pay claims as required by law. Restitution is in addition to any other penalties allowed by law, including, but not limited to, the suspension of the insurer's certificate of authority.

4. Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed.

5. Failure to maintain complaint-handling procedures.Failure of any person to maintain a complete record of all the complaints received since the date of the last examination. For purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance.

Misrepresentation in insurance applications
1. Knowingly making a false or fraudulent written or oral statement or representation on, or relative to, an application or negotiation for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual.

2. Knowingly making a material omission in the comparison of a life, health, or Medicare supplement insurance replacement policy with the policy it replaces for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual. For the purposes of this subparagraph, a material omission includes the failure to advise the insured of the existence and operation of a preexisting condition clause in the replacement policy.

3. Twisting.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 in another insurer.

Interlocking ownership and management.
1. Any domestic insurer may retain, invest in, or acquire the whole or any part of the capital stock of any other insurer or insurers, or have a common management with any other insurer or insurers, unless such retention, investment, acquisition, or common management is inconsistent

with any other provision of this code, or unless by reason thereof the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business.

2. Any person otherwise qualified may be a director of two or more domestic insurers which are competitors, unless the effect thereof is substantially to lessen competition between insurers generally or materially tend to create a monopoly.

3. Any limitation contained in this paragraph does not apply to any person who is a director of two or more insurers under common control or management.

False claims; obtaining or retaining money dishonestly.
1. Any agent, physician, claimant, or other person who causes to be presented to any insurer a false claim for payment, knowing the same to be false; or 2. Any agent, collector, or other person who represents any insurer or collects or does business without the authority of the insurer, secures cash advances by false statements, or fails to turn over when required, or satisfactorily account for, all collections of such insurer, shall, in addition to the other penalties provided in this act, be guilty of a misdemeanor of the second degree and, upon conviction thereof, shall be subject to the penalties provided by s. 775.082 or s.775.083.

Soliciting or accepting new or renewal insurance risks by insolvent or impaired insurer prohibited; penalty.
1. Whether or not delinquency proceedings as to the insurer have been or are to be initiated, but while such insolvency or impairment exists, no director or officer of an insurer, except with the written permission of the office, shall authorize or permit the insurer to solicit or accept new or renewal insurance risks in this state after such director or officer knew, or reasonably should have known, that the insurer was insolvent or impaired. "Impaired" includes impairment of capital or surplus, as defined in s. 631.011(12) and (13).

2. Any such director or officer, upon conviction of a violation of this paragraph, is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Refusal to insure. In addition to other provisions of this code, the refusal to insure, or continue to insure, any individual or risk solely because of:
1. Race, color, creed, marital status, sex, or national origin;

2. The residence, age, or lawful occupation of the individual or the location of the risk, unless there is a reasonable relationship between the residence, age, or lawful occupation of the individual or the location of the risk and the coverage issued or to be issued;

3. The insured's or applicant's failure to agree to place collateral business with any insurer, unless the coverage applied for would provide liability coverage which is excess over that provided in policies maintained on property or motor vehicles;

4. The insured's or applicant's failure to purchase noninsurance services or commodities, including automobile services as defined in s. 624.124;

5. The fact that the insured or applicant is a public official; or

6. The fact that the insured or applicant had been previously refused insurance coverage by any insurer, when such refusal to insure or continue to insure for this reason occurs with such frequency as to indicate a general business practice.

Powers of attorney.Except as provided in s. 627.842(2):
1. Requiring, as a condition to the purchase or continuation of an insurance policy, that an

applicant for insurance or an insured execute a power of attorney in favor of an insurance agent or agency or employee thereof; or

2. Presenting to the applicant or the insured, as a routine business practice, a form that authorizes the insurance agent or agency to sign the applicant's or insured's name on any insurance-related document or application for the purchase of motor vehicle services as described in s.624.124. To be valid, a power of attorney must be an act or practice other than as described in this paragraph, must be a separate writing in a separate document, must be executed with the full knowledge and consent of the applicant or insured who grants the power of attorney, must be in the best interests of the insured or applicant, and a copy of the power of attorney must be provided to the applicant or insured at the time of the transaction.

Sliding
Sliding is the act or practice of:
1. Representing to the applicant that a specific ancillary coverage or product is required by law in conjunction with the purchase of insurance when such coverage or product is not required;

2. Representing to the applicant that a specific ancillary coverage or product is included in the policy applied for without an additional charge when such charge is required; or

3. Charging an applicant for a specific ancillary coverage or product, in addition to the cost of the insurance coverage applied for, without the informed consent of the applicant.

626.9551 Favored agent or insurer; coercion of debtors
1. No person may:

a. Require, as a condition precedent or condition subsequent to the lending of money or extension of credit or any renewal thereof, that the person to whom such money or credit is extended, or whose obligation the creditor is to acquire or finance, negotiate any policy or contract of insurance through a particular insurer or group of insurers or agent or broker or group of agents or brokers.

b. Reject an insurance policy solely because the policy has been issued or underwritten by any person who is not associated with a financial institution, or with any subsidiary or affiliate thereof, when such insurance is required in connection with a loan or extension of credit; or unreasonably disapprove the insurance policy provided by a borrower for the protection of the property securing the credit or lien. For purposes of this paragraph, such disapproval shall be deemed unreasonable if it is not based solely on reasonable standards, uniformly applied, relating to the extent of coverage required by such lender or person extending credit and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for the disapproval of an insurance policy because such policy contains coverage in addition to that required.

c. Require, directly or indirectly, that any borrower, mortgagor, purchaser, insurer, broker, or agent pay a separate charge in connection with the handling of any insurance policy that is required in connection with a loan or other extension of credit or the provision of another traditional banking product, or pay a separate charge to substitute the insurance policy of one insurer for that of another, unless such charge would be required if the person were providing the insurance. This paragraph does not include the interest which may be charged on premium loans or premium advances in accordance with the security instrument.

d. Use or provide to others insurance information required to be disclosed by a customer to a financial institution, or a subsidiary or affiliate thereof, in connection with the extension of credit for the purpose of soliciting the sale of insurance, unless the customer has given express written consent or has been given the opportunity to object to such use of the information. Insurance information means information concerning premiums, terms, and conditions of insurance

coverage, insurance claims, and insurance history provided by the customer. The opportunity to object to the use of insurance information must be in writing and must be clearly and conspicuously made.

2a. Any person offering the sale of insurance at the time of and in connection with an extension of credit or the sale or lease of goods or services shall disclose in writing that the choice of an insurance provider will not affect the decision regarding the extension of credit or sale or lease of goods or services, except that reasonable requirements may be imposed pursuant to subsection (1).

2b. Federally insured or state-insured depository institutions and credit unions shall make clear and conspicuous disclosure in writing prior to the sale of any insurance policy that such policy is not a deposit, is not insured by the Federal Deposit Insurance Corporation or any other entity, is not guaranteed by the insured depository institution or any person soliciting the purchase of or selling the policy; that the financial institution is not obligated to provide benefits under the insurance contract; and, where appropriate, that the policy involves investment risk, including potential loss of principal.

2c. All documents constituting policies of insurance shall be separate and shall not be combined with or be a part of other documents. A person may not include the expense of insurance premiums in a primary credit transaction without the express written consent of the customer.

626.9561 Power of department and office
The department and office shall each have power within its respective regulatory jurisdiction to examine and investigate the affairs of every person involved in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by s. 626.9521, and shall each have the powers and duties specified in ss.626.9571-626.9601 in connection therewith.

626.9571 Defined practices; hearings, witnesses, appearances, production of books and service of process
1. Whenever the department or office has reason to believe that any person has engaged, or is engaging, in this state in any unfair method of competition or any unfair or deceptive act or practice as defined in s. 626.9541 or s. 626.9551 or is engaging in the business of insurance without being properly licensed as required by this code and that a proceeding by it in respect thereto would be to the interest of the public, it shall conduct or cause to have conducted a hearing in accordance with chapter 120.

2. The department or office, a duly empowered hearing officer, or an administrative law judge shall, during the conduct of such hearing, have those powers enumerated in s. 120.569; however, the penalties for failure to comply with a subpoena or with an order directing discovery shall be limited to a fine not to exceed $1,000 per violation.

3. Statements of charges, notices, and orders under this act may be served by anyone duly authorized by the department or office, either in the manner provided by law for service of process in civil actions or by certifying and mailing a copy thereof to the person affected by such statement, notice, order, or other process at his or her or its residence or principal office or place of business. The verified return by the person so serving such statement, notice, order, or other process, setting forth the manner of the service, shall be proof of the same, and the return postcard receipt for such statement, notice, order, or other process, certified and mailed as aforesaid, shall be proof of service of the same.

626.9702 Illegal dealings in premiums; excess charges for insurance
1. No insurer shall impose or request an additional premium for automobile insurance, or refuse to renew a policy, solely because the insured or applicant was convicted of one or more traffic

violations which do not involve an accident or do not cause revocation or suspension of the driving privileges of the insured, without adequate proof of a direct, demonstrable, objective relationship between the violation for which the surcharge was imposed and the increased risk of highway accidents.

2. No insurer shall cancel or otherwise terminate any automobile insurance contract with an insured after the insured has paid the premiums on such policy for 5 years or more solely because the insured is involved in a single traffic accident.

3. Any person or organization which violates any provision of this section shall be subject to the penalties provided in s. 627.381.

626.9705 Life or disability insurance; illegal dealings
1. No life or disability insurer shall refuse to renew, sell, or issue a life or disability insurance policy, establish or charge a premium or rate to an applicant or a prospective policyholder, or establish or charge an unfair, discriminatory premium or rate to such person solely on the ground that the applicant or policyholder suffers from a severe disability.

2. "Severe disability," as used in this section, means any spinal cord disease or injury resulting in permanent and total disability, amputation of any extremity that requires prosthesis, permanent visual acuity of 20/200 or worse in the better eye with the best correction, a peripheral field so contracted that the widest diameter of such field subtends an angular distance no greater than 20 degrees, or neurosensory deafness.

3. Nothing in this section should be construed as requiring an insurer to provide insurance coverage against a severe disability which the applicant or policyholder has already sustained.

626.9707 Disability insurance; discrimination on basis of sickle-cell trait prohibited
1. No insurer authorized to transact insurance in this state shall refuse to issue and deliver in this state any policy of disability insurance, whether such policy is defined as individual, group, blanket, franchise, industrial, or otherwise, which is currently being issued for delivery in this state and which affords benefits and coverage for any medical treatment or service authorized and permitted to be furnished by a hospital, clinic, health clinic, neighborhood health clinic, health maintenance organization, physician, physician's assistant, nurse practitioner, or medical service facility or personnel solely because the person to be insured has the sickle-cell trait.

2. No disability insurance policy issued or delivered in this state shall carry a higher premium rate or charge solely because the person to be insured has the sickle-cell trait.

Understanding Required Premium Discounts
Insurers are not legally required to offer premium discounts to applicants and policy holders, however, if you're eligible to shop in the Health Insurance Marketplace, you can apply for financial assistance from the government to help cover monthly premiums and out-of-pocket expenses.

The Affordable Care Act created health insurance discount options, depending on your household income and family size.

Help with premium payments

The premium tax credit or subsidy lowers your monthly premium payments. The federal government can pay part of the premium to your insurance company or you can claim the full amount of the premium tax credit when filing your tax return.