An act relating to the Florida Workers' Compensation Joint Underwriting Association, Inc.; amending s. 627.311, F.S.; providing requirements for the joint underwriting plan of insurers which operates as the association; revising the membership of the board of governors that oversees operation of the joint underwriting plan; revising restrictions on who may serve on the board; providing for the continuous review of the plan; requiring that the market-assistance plan be periodically reviewed and updated; providing guidelines for procurement of goods and services, including legal services; authorizing the use of surplus funds of former plan C; requiring that excess funds received by the plan be returned to the state; providing for the applicability of specified statutes regulating ethical standards; requiring annual statements by plan employees certifying that they do not have conflicts of interest; prescribing limits on representing persons or entities before the plan by former senior managers or officers of the plan; prohibiting any part of the plan's income from inuring to the benefit of a private individual; prohibiting employees and board members from accepting expenditures from a person or an entity; providing applicability; requiring periodic comprehensive market examinations; prescribing the disposition of

assets of the plan upon dissolution; requiring that the plan submit a request for an Internal Revenue Service letter concerning the plan's eligibility as a tax-exempt entity; providing an effective date.

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

Section 1. Subsections (5), (6), and (7) of section 627.311, Florida Statutes, are amended to read:

627.311 Joint underwriters and joint reinsurers; public records and public meetings exemptions.--

(5)(a) The office shall, after consultation with insurers, approve a joint underwriting plan of insurers which shall operate as the Florida Workers' Compensation Joint Underwriting Association, Inc., a nonprofit entity. For the purposes of this subsection, the term "insurer" includes group self-insurance funds authorized by s. 624.4621, commercial self-insurance funds authorized by s. 624.462, assessable mutual insurers authorized under s. 628.6011, and insurers licensed to write workers' compensation and employer's liability insurance in this state. The purpose of the plan is to provide workers' compensation and employer's liability insurance to applicants who are required by law to maintain workers' compensation and employer's liability insurance and who are in good faith entitled to but who are unable to procure such insurance through the voluntary market. Except as provided herein, the plan must have actuarially sound rates that ensure that the plan is self-supporting.

(b) The operation of the plan is subject to the supervision of a 9-member board of governors. Each member

described in subparagraph 1., subparagraph 2., subparagraph 3., or subparagraph 5. shall be appointed by the Financial Services Commission and shall serve at the pleasure of the commission. The board of governors shall be comprised of:

~~1. Three members appointed by the Financial Services Commission. Each member appointed by the commission shall serve at the pleasure of the commission;~~

1.~~2.~~ Two representatives of the 20 domestic insurers, as defined in s. 624.06(1), having the largest voluntary direct premiums written in this state for workers' compensation and employer's liability insurance who~~, which~~ shall be appointed by the commission from a list of five nominees for each vacancy submitted ~~elected~~ by those 20 domestic insurers. The commission may reject all of the nominees recommended for a position and request that the insurers submit a new list of five different recommended nominees for the position who have not previously been recommended by the insurers;

2.~~3.~~ Two representatives of the 20 foreign insurers as defined in s. 624.06(2) having the largest voluntary direct premiums written in this state for workers' compensation and employer's liability insurance who~~, which~~ shall be appointed by the commission from a list of five nominees for each vacancy submitted ~~elected~~ by those 20 foreign insurers. The commission may reject all of the nominees recommended for a position and request that the insurers submit a new list of five different recommended nominees for the position who have not previously been recommended by the insurers;

3.~~4.~~ One representative of ~~person appointed by~~ the largest property and casualty insurance agents' association in this state who shall be appointed by the commission from a

list of five nominees for each vacancy submitted by the association. The commission may reject all of the nominees recommended for a position and request that the association submit a new list of five different recommended nominees for the position who have not previously been recommended by the association; ~~and~~

4.~~5.~~ The consumer advocate appointed under s. 627.0613 or the consumer advocate's designee; and~~.~~

5. Three other persons appointed by the commission.

Each board member shall be appointed to ~~serve~~ a 4-year term and may be appointed to ~~serve~~ consecutive terms. A vacancy on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term. The Financial Services Commission shall designate a member of the board to serve as chair. ~~No board member shall be an insurer which provides services to the plan or which has an affiliate which provides services to the plan or which is serviced by a service company or third party administrator which provides services to the plan or which has an affiliate which provides services to the plan.~~ The meetings and records ~~minutes, audits, and procedures~~ of the board of governors and plan are subject to chapters ~~chapter~~ 119 and 286, unless otherwise exempted by law.

(c) The operation of the plan shall be governed by a plan of operation that is prepared at the direction of the board of governors and approved by order of the office. The plan is subject to continuous review by the office. The office may, by order, withdraw approval of all or part of a plan if the office determines that conditions have changed since approval was granted and that the purposes of the plan require

changes in the plan. ~~The plan of operation may be changed at any time by the board of governors or upon request of the office. The plan of operation and all changes thereto are subject to the approval of the office.~~ The plan of operation shall:

1. Authorize the board to engage in the activities necessary to implement this subsection, including, but not limited to, borrowing money.

2. Develop criteria for eligibility for coverage by the plan, including, but not limited to, documented rejection by at least two insurers which reasonably assures that insureds covered under the plan are unable to acquire coverage in the voluntary market.

3. Require notice from the agent to the insured at the time of the application for coverage that the application is for coverage with the plan and that coverage may be available through an insurer, group self-insurers' fund, commercial self-insurance fund, or assessable mutual insurer through another agent at a lower cost.

4. Establish programs to encourage insurers to provide coverage to applicants of the plan in the voluntary market and to insureds of the plan, including, but not limited to:

a. Establishing procedures for an insurer to use in notifying the plan of the insurer's desire to provide coverage to applicants to the plan or existing insureds of the plan and in describing the types of risks in which the insurer is interested. The description of the desired risks must be on a form developed by the plan.

b. Developing forms and procedures that provide an insurer with the information necessary to determine whether

the insurer wants to write particular applicants to the plan or insureds of the plan.

c. Developing procedures for notice to the plan and the applicant to the plan or insured of the plan that an insurer will insure the applicant or the insured of the plan, and notice of the cost of the coverage offered; and developing procedures for the selection of an insuring entity by the applicant or insured of the plan.

d. Provide for a market-assistance plan to assist in the placement of employers. All applications for coverage in the plan received 45 days before the effective date for coverage shall be processed through the market-assistance plan. A market-assistance plan specifically designed to serve the needs of small, good policyholders as defined by the board must be reviewed and updated periodically ~~finalized by January 1, 1994~~.

5. Provide for policy and claims services to the insureds of the plan of the nature and quality provided for insureds in the voluntary market.

6. Provide for the review of applications for coverage with the plan for reasonableness and accuracy, using any available historic information regarding the insured.

7. Provide for procedures for auditing insureds of the plan which are based on reasonable business judgment and are designed to maximize the likelihood that the plan will collect the appropriate premiums.

8. Authorize the plan to terminate the coverage of and refuse future coverage for any insured that submits a fraudulent application to the plan or provides fraudulent or grossly erroneous records to the plan or to any service

provider of the plan in conjunction with the activities of the plan.

9. Establish service standards for agents who submit business to the plan.

10. Establish criteria and procedures to prohibit any agent who does not adhere to the established service standards from placing business with the plan or receiving, directly or indirectly, any commissions for business placed with the plan.

11. Provide for the establishment of reasonable safety programs for all insureds in the plan. All insureds of the plan must participate in the safety program.

12. Authorize the plan to terminate the coverage of and refuse future coverage to any insured who fails to pay premiums or surcharges when due; who, at the time of application, is delinquent in payments of workers' compensation or employer's liability insurance premiums or surcharges owed to an insurer, group self-insurers' fund, commercial self-insurance fund, or assessable mutual insurer licensed to write such coverage in this state; or who refuses to substantially comply with any safety programs recommended by the plan.

13. Authorize the board of governors to provide the goods and services required by the plan through staff employed by the plan, through reasonably compensated service providers who contract with the plan to provide services as specified by the board of governors, or through a combination of employees and service providers.

a. Purchases that equal or exceed $2,500 but are less than or equal to $25,000, shall be made by receipt of written quotes, telephone quotes, or informal bids, whenever practical. The procurement of goods or services valued over

$25,000 are subject to competitive solicitation, except in situations in which the goods or services are provided by a sole source or are deemed an emergency purchase, or the services are exempted from competitive-solicitation requirements under s. 287.057(5)(f). Justification for the sole-sourcing or emergency procurement must be documented. Contracts for goods or services valued at or over $100,000 are subject to board approval.

b. The board shall determine whether it is more cost-effective and in the best interests of the plan to use legal services provided by in-house attorneys employed by the plan rather than contracting with outside counsel. In making such determination, the board shall document its findings and shall consider the expertise needed; whether time commitments exceed in-house staff resources; whether local representation is needed; the travel, lodging, and other costs associated with in-house representation; and such other factors that the board determines are relevant.

14. Provide for service standards for service providers, methods of determining adherence to those service standards, incentives and disincentives for service, and procedures for terminating contracts for service providers that fail to adhere to service standards.

15. Provide procedures for selecting service providers and standards for qualification as a service provider that reasonably assure that any service provider selected will continue to operate as an ongoing concern and is capable of providing the specified services in the manner required.

16. Provide for reasonable accounting and data-reporting practices.

17. Provide for annual review of costs associated with the administration and servicing of the policies issued by the plan to determine alternatives by which costs can be reduced.

18. Authorize the acquisition of such excess insurance or reinsurance as is consistent with the purposes of the plan.

19. Provide for an annual report to the office on a date specified by the office and containing such information as the office reasonably requires.

20. Establish multiple rating plans for various classifications of risk which reflect risk of loss, hazard grade, actual losses, size of premium, and compliance with loss control. At least one of such plans must be a preferred-rating plan to accommodate small-premium policyholders with good experience as defined in sub-subparagraph 22.a.

21. Establish agent commission schedules.

22. For employers otherwise eligible for coverage under the plan, establish three tiers of employers meeting the criteria and subject to the rate limitations specified in this subparagraph.

a. Tier One.--

(I) Criteria; rated employers.--An employer that has an experience modification rating shall be included in Tier One if the employer meets all of the following:

(A) The experience modification is below 1.00.

(B) The employer had no lost-time claims subsequent to the applicable experience modification rating period.

(C) The total of the employer's medical-only claims subsequent to the applicable experience modification rating period did not exceed 20 percent of premium.

(II) Criteria; non-rated employers.--An employer that does not have an experience modification rating shall be included in Tier One if the employer meets all of the following:

(A) The employer had no lost-time claims for the 3-year period immediately preceding the inception date or renewal date of the employer's coverage under the plan.

(B) The total of the employer's medical-only claims for the 3-year period immediately preceding the inception date or renewal date of the employer's coverage under the plan did not exceed 20 percent of premium.

(C) The employer has secured workers' compensation coverage for the entire 3-year period immediately preceding the inception date or renewal date of the employer's coverage under the plan.

(D) The employer is able to provide the plan with a loss history generated by the employer's prior workers' compensation insurer, except if the employer is not able to produce a loss history due to the insolvency of an insurer, the receiver shall provide to the plan, upon the request of the employer or the employer's agent, a copy of the employer's loss history from the records of the insolvent insurer if the loss history is contained in records of the insurer which are in the possession of the receiver. If the receiver is unable to produce the loss history, the employer may, in lieu of the loss history, submit an affidavit from the employer and the employer's insurance agent setting forth the loss history.

(E) The employer is not a new business.

(III) Premiums.--The premiums for Tier One insureds shall be set at a premium level 25 percent above the comparable voluntary market premiums until the plan has

sufficient experience as determined by the board to establish an actuarially sound rate for Tier One, at which point the board shall, subject to paragraph (e), adjust the rates, if necessary, to produce actuarially sound rates, provided such rate adjustment shall not take effect prior to January 1, 2007.

b. Tier Two.--

(I) Criteria; rated employers.--An employer that has an experience modification rating shall be included in Tier Two if the employer meets all of the following:

(A) The experience modification is equal to or greater than 1.00 but not greater than 1.10.

(B) The employer had no lost-time claims subsequent to the applicable experience modification rating period.

(C) The total of the employer's medical-only claims subsequent to the applicable experience modification rating period did not exceed 20 percent of premium.

(II) Criteria; non-rated employers.--An employer that does not have any experience modification rating shall be included in Tier Two if the employer is a new business. An employer shall be included in Tier Two if the employer has less than 3 years of loss experience in the 3-year period immediately preceding the inception date or renewal date of the employer's coverage under the plan and the employer meets all of the following:

(A) The employer had no lost-time claims for the 3-year period immediately preceding the inception date or renewal date of the employer's coverage under the plan.

(B) The total of the employer's medical-only claims for the 3-year period immediately preceding the inception date

or renewal date of the employer's coverage under the plan did not exceed 20 percent of premium.

(C) The employer is able to provide the plan with a loss history generated by the workers' compensation insurer that provided coverage for the portion or portions of such period during which the employer had secured workers' compensation coverage, except if the employer is not able to produce a loss history due to the insolvency of an insurer, the receiver shall provide to the plan, upon the request of the employer or the employer's agent, a copy of the employer's loss history from the records of the insolvent insurer if the loss history is contained in records of the insurer which are in the possession of the receiver. If the receiver is unable to produce the loss history, the employer may, in lieu of the loss history, submit an affidavit from the employer and the employer's insurance agent setting forth the loss history.

(III) Premiums.--The premiums for Tier Two insureds shall be set at a rate level 50 percent above the comparable voluntary market premiums until the plan has sufficient experience as determined by the board to establish an actuarially sound rate for Tier Two, at which point the board shall, subject to paragraph (e), adjust the rates, if necessary, to produce actuarially sound rates, provided such rate adjustment shall not take effect prior to January 1, 2007.

c. Tier Three.--

(I) Eligibility.--An employer shall be included in Tier Three if the employer does not meet the criteria for Tier One or Tier Two.

(II) Rates.--The board shall establish, subject to paragraph (e), and the plan shall charge, actuarially sound rates for Tier Three insureds.

23. For Tier One or Tier Two employers which employ no nonexempt employees or which report payroll which is less than the minimum wage hourly rate for one full-time employee for 1 year at 40 hours per week, the plan shall establish actuarially sound premiums, provided, however, that the premiums may not exceed $2,500. These premiums shall be in addition to the fee specified in subparagraph 26. When the plan establishes actuarially sound rates for all employers in Tier One and Tier Two, the premiums for employers referred to in this paragraph are no longer subject to the $2,500 cap.

24. Provide for a depopulation program to reduce the number of insureds in the plan. If an employer insured through the plan is offered coverage from a voluntary market carrier:

a. During the first 30 days of coverage under the plan;

b. Before a policy is issued under the plan;

c. By issuance of a policy upon expiration or cancellation of the policy under the plan; or

d. By assumption of the plan's obligation with respect to an in-force policy,

that employer is no longer eligible for coverage through the plan. The premium for risks assumed by the voluntary market carrier must be no greater than the premium the insured would have paid under the plan, and shall be adjusted upon renewal to reflect changes in the plan rates and the tier for which the insured would qualify as of the time of renewal. The insured may be charged such premiums only for the first 3

years of coverage in the voluntary market. A premium under this subparagraph is deemed approved and is not an excess premium for purposes of s. 627.171.

25. Require that policies issued and applications must include a notice that the policy could be replaced by a policy issued from a voluntary market carrier and that, if an offer of coverage is obtained from a voluntary market carrier, the policyholder is no longer eligible for coverage through the plan. The notice must also specify that acceptance of coverage under the plan creates a conclusive presumption that the applicant or policyholder is aware of this potential.

26. Require that each application for coverage and each renewal premium be accompanied by a nonrefundable fee of $475 to cover costs of administration and fraud prevention. The board may, with the prior approval of the office, increase the amount of the fee pursuant to a rate filing to reflect increased costs of administration and fraud prevention. The fee is not subject to commission and is fully earned upon commencement of coverage.

(d)1. The funding of the plan shall include premiums as provided in subparagraph (c)22. and assessments as provided in this paragraph.

2.a. If the board determines that a deficit exists in Tier One or Tier Two or that there is any deficit remaining attributable to any of the plan's former subplans and that the deficit cannot be fully funded by using policyholder surplus attributable to former subplan C or, if the surplus in the former subplan C does not fully fund the deficit ~~without the use of deficit assessments~~, the board shall request the office to levy, by order, a deficit assessment against premiums charged to insureds for workers' compensation insurance by

insurers as defined in s. 631.904(5). The office shall issue the order after verifying the amount of the deficit. The assessment shall be specified as a percentage of future premium collections, as recommended by the board and approved by the office. The same percentage shall apply to premiums on all workers' compensation policies issued or renewed during the 12-month period beginning on the effective date of the assessment, as specified in the order.

b. With respect to each insurer collecting premiums that are subject to the assessment, the insurer shall collect the assessment at the same time as the insurer collects the premium payment for each policy and shall remit the assessments collected to the plan as provided in the order issued by the office. The office shall verify the accurate and timely collection and remittance of deficit assessments and shall report such information to the board. Each insurer collecting assessments shall provide such information with respect to premiums and collections as may be required by the office to enable the office to monitor and audit compliance with this paragraph.

c. Deficit assessments are not considered part of an insurer's rate, are not premium, and are not subject to the premium tax, to the assessments under ss. 440.49 and 440.51, to the surplus lines tax, to any fees, or to any commissions. The deficit assessment imposed shall become plan funds at the moment of collection and shall not constitute income to the insurer for any purpose, including financial reporting on the insurer's income statement. An insurer is liable for all assessments that the insurer collects and must treat the failure of an insured to pay an assessment as a failure to pay

premium. An insurer is not liable for uncollectible assessments.

d. When an insurer is required to return unearned premium, the insurer shall also return any collected assessments attributable to the unearned premium.

e. Deficit assessments as described in this subparagraph shall not be levied after July 1, 2012 ~~2007~~.

3.a. All policies issued to Tier Three insureds shall be assessable. All Tier Three assessable policies must be clearly identified as assessable by containing, in contrasting color and in not less than 10-point type, the following statement:

"This is an assessable policy. If the plan is unable to pay its obligations, policyholders will be required to contribute on a pro rata earned premium basis the money necessary to meet any assessment levied."

b. The board may from time to time assess Tier Three insureds to whom the plan has issued assessable policies for the purpose of funding plan deficits. Any such assessment shall be based upon a reasonable actuarial estimate of the amount of the deficit, taking into account the amount needed to fund medical and indemnity reserves and reserves for incurred but not reported claims, and allowing for general administrative expenses, the cost of levying and collecting the assessment, a reasonable allowance for estimated uncollectible assessments, and allocated and unallocated loss adjustment expenses.

c. Each Tier Three insured's share of a deficit shall be computed by applying to the premium earned on the insured's policy or policies during the period to be covered by the assessment the ratio of the total deficit to the total premiums earned during such period upon all policies subject to the assessment. If one or more Tier Three insureds fail to pay an assessment, the other Tier Three insureds shall be liable on a proportionate basis for additional assessments to fund the deficit. The plan may compromise and settle individual assessment claims without affecting the validity of or amounts due on assessments levied against other insureds. The plan may offer and accept discounted payments for assessments which are promptly paid. The plan may offset the amount of any unpaid assessment against unearned premiums which may otherwise be due to an insured. The plan shall institute legal action when necessary and appropriate to collect the assessment from any insured who fails to pay an assessment when due.

d. The venue of a proceeding to enforce or collect an assessment or to contest the validity or amount of an assessment shall be in the Circuit Court of Leon County.

e. If the board finds that a deficit in Tier Three exists for any period and that an assessment is necessary, the board shall certify to the office the need for an assessment. No sooner than 30 days after the date of such certification, the board shall notify in writing each insured who is to be assessed that an assessment is being levied against the insured, and informing the insured of the amount of the assessment, the period for which the assessment is being levied, and the date by which payment of the assessment is due. The board shall establish a date by which payment of the

assessment is due, which shall be no sooner than 30 days nor later than 120 days after the date on which notice of the assessment is mailed to the insured.

f. Whenever the board makes a determination that the plan does not have a sufficient cash basis to meet 6 ~~3~~ months of projected cash needs due to a deficit in Tier Three, the board may request the department to transfer funds from the Workers' Compensation Administration Trust Fund to the plan in an amount sufficient to fund the difference between the amount available and the amount needed to meet a 6-month ~~3 month~~ projected cash need as determined by the board and verified by the office, subject to the approval of the Legislative Budget Commission. If the Legislative Budget Commission approves a transfer of funds under this sub-subparagraph, the plan shall report to the Legislature the transfer of funds and the Legislature shall review the plan during the next legislative session or the current legislative session, if the transfer occurs during a legislative session. This sub-subparagraph shall not apply until the plan determines and the office verifies that assessments collected by the plan pursuant to sub-subparagraph b. are insufficient to fund the deficit in Tier Three and to meet 6 ~~3~~ months of projected cash needs.

4. The plan may offer rating, dividend plans, and other plans to encourage loss prevention programs.

(e) For rates and rating plans effective on or after January 1, 2008, the plan shall establish and use its rates and rating plans, and the plan may establish and use changes in rating plans at any time, but no more frequently than two times per any rating class for any calendar year. By ~~December 1, 1993, and~~ December 1 of each year thereafter, except as provided in subparagraph (c)22., the board shall establish and

use actuarially sound rates for use by the plan to assure that the plan is self-funding while those rates are in effect. Such rates and rating plans must be filed with the office within 30 calendar days after their effective dates, and shall be considered a "use and file" filing. Any disapproval by the office must have an effective date that is at least 60 days from the date of disapproval of the rates and rating plan and must have prospective effect only. The plan shall ~~may not~~ be subject to any order by the office to return to policyholders any portion of the rates disapproved by the office. The office may not disapprove any rates or rating plans unless it demonstrates that such rates and rating plans are excessive, inadequate, or unfairly discriminatory.

(f) No later than June 1 of each year, the plan shall obtain an independent actuarial certification of the results of the operations of the plan for prior years, and shall furnish a copy of the certification to the office. If, after the effective date of the plan, the projected ultimate incurred losses and expenses and dividends for prior years exceed collected premiums, accrued net investment income, and prior assessments for prior years, the certification is subject to review and approval by the office before it becomes final.

(g) Whenever a deficit exists, the plan shall, within 90 days, provide the office with a program to eliminate the deficit within a reasonable time. The deficit may be funded through increased premiums charged to insureds of the plan for subsequent years, through the use of policyholder surplus attributable to any year, including policyholder surplus in former subplan C as authorized in subparagraph (d)2., through the use of assessments as provided in subparagraph (d)2., and

through assessments on assessable policies as provided in subparagraph (d)3. Any entity that was a policyholder of former subplan C is not subject to any assessments that are attributable to deficits in former subplan C.

(h) Any premium or assessments collected by the plan in excess of the amount necessary to fund projected ultimate incurred losses and expenses of the plan and not paid to insureds of the plan in conjunction with loss prevention or dividend programs shall be retained by the plan for future use. Any state funds received by the plan in excess of the amount necessary to fund deficits in subplan D or any tier shall be returned to the state.

(i) The decisions of the board of governors do not constitute final agency action and are not subject to chapter 120.

(j) Policies for insureds shall be issued by the plan.

(k) The plan created under this subsection is liable only for payment for losses arising under policies issued by the plan with dates of accidents occurring on or after January 1, 1994.

(l) Plan losses are the sole and exclusive responsibility of the plan, and payment for such losses must be funded in accordance with this subsection and must not come, directly or indirectly, from insurers or any guaranty association for such insurers.

(m) Senior managers and officers, as defined in the plan of operation, and members of the board of governors are subject to the provisions of ss. 112.313, 112.3135, 112.3143, 112.3145, 112.316, and 112.317. Senior managers, officers, and board members are also required to file such disclosures with the Commission on Ethics and the Office of Insurance

Regulation. The executive director of the plan or his or her designee shall notify each newly appointed and existing appointed member of the board of governors, senior manager, and officer of their duty to comply with the reporting requirements of s. 112.345. At least quarterly, the executive director of the plan or his or her designee shall submit to the Commission on Ethics a list of names of the senior managers, officers, and members of the board of governors who are subject to the public disclosure requirements under s. 112.3145. Notwithstanding s. 112.313, an employee, officer, owner, or director of an insurance agency, insurance company, or other insurance entity may be a member of the board of governors unless such employee, officer, owner, or director of an insurance agency, insurance company, other insurance entity, or an affiliate provides policy issuance, policy administration, underwriting, claims handling, or payroll audit services. Notwithstanding s. 112.3143, such board member may not participate in or vote on a matter if the insurance agency, insurance company, or other insurance entity would obtain a special or unique benefit that would not apply to other similarly situated insurance entities. ~~Each joint underwriting plan or association created under this section is not a state agency, board, or commission. However, for the purposes of s. 199.183(1) only, the joint underwriting plan is a political subdivision of the state and is exempt from the corporate income tax.~~

(n) On or before July 1 of each year, employees of the plan shall sign and submit a statement to the plan attesting that they do not have a conflict of interest as defined in part III of chapter 112. As a condition of employment, all prospective employees shall sign and submit a

conflict-of-interest statement to the plan. ~~Each joint underwriting plan or association may elect to pay premium taxes on the premiums received on its behalf or may elect to have the member insurers to whom the premiums are allocated pay the premium taxes if the member insurer had written the policy. The joint underwriting plan or association shall notify the member insurers and the Department of Revenue by January 15 of each year of its election for the same year. As used in this paragraph, the term "premiums received" means the consideration for insurance, by whatever name called, but does not include any policy assessment or surcharge received by the joint underwriting association as a result of apportioning losses or deficits of the association pursuant to this section.~~

(o) Any senior manager or officer of the plan who is employed by the plan as of January 1, 2008, regardless of the date of hire, and who subsequently retires or terminates employment may not represent another person or entity before the plan for 2 years after retirement or termination of employment from the plan.

(p) No part of the income of the plan may inure to the benefit of any private person.

(q) Notwithstanding ss. 112.3148 and 112.3149 or other provision of law, an employee or board member may not knowingly accept, directly or indirectly, any expenditure or gift from a person or entity, or an employee or representative of such person or entity, which has a contractual relationship with the plan or is under consideration for a contract. An employee or board member who fails to comply with paragraph (m) or this paragraph is subject to penalties provided under s. 112.317.

(r) This section does not prohibit the plan from providing insurance coverage to any employer with whom a former employee of the plan is affiliated or employing or reemploying any former employee of the plan in a part-time, full-time, temporary, or permanent capacity, so long as such employment does not violate any provision of part III of chapter 112.

(s)~~(o)~~ Neither the plan nor any member of the board of governors is liable for monetary damages to any person for any statement, vote, decision, or failure to act, regarding the management or policies of the plan, unless:

1. The member breached or failed to perform her or his duties as a member; and

2. The member's breach of, or failure to perform, duties constitutes:

a. A violation of the criminal law, unless the member had reasonable cause to believe her or his conduct was not unlawful. A judgment or other final adjudication against a member in any criminal proceeding for violation of the criminal law estops that member from contesting the fact that her or his breach, or failure to perform, constitutes a violation of the criminal law; but does not estop the member from establishing that she or he had reasonable cause to believe that her or his conduct was lawful or had no reasonable cause to believe that her or his conduct was unlawful;

b. A transaction from which the member derived an improper personal benefit, either directly or indirectly; or

c. Recklessness or any act or omission that was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human

rights, safety, or property. For purposes of this sub-subparagraph, the term "recklessness" means the acting, or omission to act, in conscious disregard of a risk:

(I) Known, or so obvious that it should have been known, to the member; and

(II) Known to the member, or so obvious that it should have been known, to be so great as to make it highly probable that harm would follow from such act or omission.

(t)~~(p)~~ No insurer shall provide workers' compensation and employer's liability insurance to any person who is delinquent in the payment of premiums, assessments, penalties, or surcharges owed to the plan or to any person who is an affiliated person of a person who is delinquent in the payment of premiums, assessments, penalties, or surcharges owed to the plan. For purposes of this paragraph, the term "affiliated person" of another person means:

1. The spouse of such other natural person;

2. Any person who directly or indirectly owns or controls, or holds with the power to vote, 5 percent or more of the outstanding voting securities of such other person;

3. Any person who directly or indirectly owns 5 percent or more of the outstanding voting securities that are directly or indirectly owned or controlled, or held with the power to vote, by such other person;

4. Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;

5. Any officer, director, trustee, partner, owner, manager, joint venturer, or employee, or other person performing duties similar to persons in those positions, of such other persons; or

6. Any person who has an officer, director, trustee, partner, or joint venturer in common with such other person.

(u)~~(q)~~ Effective July 1, 2004, the plan is exempt from the premium tax under s. 624.509 and any assessments under ss. 440.49 and 440.51.

(v) The Office of Insurance Regulation shall perform a comprehensive market conduct examination of the plan periodically to determine compliance with its plan of operation and internal operating policies and procedures.

(w) Upon dissolution, the assets of the plan shall be applied first to pay all debts, liabilities, and obligations of the plan, including the establishment of reasonable reserves for any contingent liabilities or obligations, and all remaining assets of the plan shall become property of the state and shall be deposited in the Workers' Compensation Administration Trust Fund. However, dissolution may not take effect as long as the plan has financial obligations outstanding unless adequate provision has been made for the payment of financial obligations pursuant to the documents authorizing the financial obligations.

(6) Each joint underwriting plan or association created under this section is not a state agency, board, or commission. However, for the purposes of s. 199.183(1) only, the joint underwriting plan created under subsection (5) is a political subdivision of the state and is exempt from the corporate income tax.

(7) Each joint underwriting plan or association may elect to pay premium taxes on the premiums received on its behalf or may elect to have the member insurers to whom the premiums are allocated pay the premium taxes if the member insurer had written the policy. The joint underwriting plan or

association shall notify the member insurers and the Department of Revenue by January 15 of each year of its election for the same year. As used in this paragraph, the term "premiums received" means the consideration for insurance, by whatever name called, but does not include any policy assessment or surcharge received by the joint underwriting association as a result of apportioning losses or deficits of the association pursuant to this section.

(8)~~(6)~~ As used in this section and ss. 215.555 and 627.351, the term "collateral protection insurance" means commercial property insurance of which a creditor is the primary beneficiary and policyholder and which protects or covers an interest of the creditor arising out of a credit transaction secured by real or personal property. Initiation of such coverage is triggered by the mortgagor's failure to maintain insurance coverage as required by the mortgage or other lending document. Collateral protection insurance is not residential coverage.

(9)~~(7)~~(a) The Florida Automobile Joint Underwriting Association created under this section shall be deemed to have appointed its general manager as its agent to receive service of all legal process issued against the association in any civil action or proceeding in this state. Process so served shall be valid and binding upon the insurer.

(b) Service of process upon the association's general manager as the association's agent pursuant to such an appointment shall be the sole method of service of process upon the association.

Section 2. No later than January 1, 2008, the Florida Workers' Compensation Joint Underwriting Association, Inc., shall submit a request to the Internal Revenue Service for a

letter ruling or determination on the plan's eligibility as a tax-exempt entity.

Section 3. This act shall take effect July 1, 2007.