By Senator DiCeglie

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A bill to be entitled

An act relating to consumer protection in insurance matters; amending s. 626.854, F.S.; requiring public adjusters, public adjuster apprentices, and public adjusting firms to provide a specified response within a specified timeframe after receiving a request for claim status from a claimant, an insured, or a designated representative; requiring such adjusters, apprentices, and firms to retain a copy of such response; creating s. 627.4815, F.S.; defining terms; requiring that universal life insurance policies include a provision requiring a certain annual report; specifying requirements for the annual report; providing applicability; amending s. 627.6515, F.S.; revising applicability relating to group health insurance policies; creating s. 627.7293, F.S.; requiring certain automobile insurers, under certain circumstances, to provide a specified statement in a certain manner; requiring the automobile insurer to obtain express consent before submitting specified claims; providing applicability; creating s. 627.7431, F.S.; defining terms; requiring insurers to pay or deny certain claims within a specified timeframe; providing an exception; requiring insurers to provide certain explanations to policyholders under certain circumstances; specifying that certain payments bear specified interest; specifying when the interest begins to accrue; providing construction; requiring the insured to select the manner of receiving

prejudgment interest under certain circumstances; specifying that the failure to comply with certain provisions does not form the basis of a private cause of action; providing applicability; specifying that certain requirements are tolled under certain circumstances; providing an effective date.

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

Section 1. Subsection (24) is added to section 626.854, Florida Statutes, to read:

626.854 "Public adjuster" defined; prohibitions.—The Legislature finds that it is necessary for the protection of the public to regulate public insurance adjusters and to prevent the unauthorized practice of law.

(24) A public adjuster, public adjuster apprentice, or public adjusting firm must provide a specific response to a written or electronic request for claim status from a claimant, an insured, or the person's designated representative within 14 days after receiving the request. The public adjuster, public adjuster apprentice, or public adjusting firm must retain a copy of its response for its records.

Section 2. Section 627.4815, Florida Statutes, is created to read:

627.4815 Universal life policies.—

(1) As used in this section, the term:

(a) "Cash surrender value" means the net cash surrender value plus any amounts outstanding as policy loans.

(b) "Fixed premium universal life insurance policy" means a

universal life insurance policy other than a flexible premium universal life insurance policy.

(c) "Flexible premium universal life insurance policy" means a universal life insurance policy that permits the policyowner to vary, independently of each other, the amount or timing of one or more premium payments or the amount of insurance.

(d) "Net cash surrender value" means the maximum amount payable to the policyowner upon surrender.

(e) "Policy value" means the value of any individual life insurance policy, rider, group master policy, or individual certificate. The term includes separately identified interest credits, except those related to dividend accumulations, premium deposit funds, or other supplementary accounts, and mortality and expense charges.

(f) "Universal life insurance policy" means any individual life insurance policy, rider, group master policy, or individual certificate that includes separately identified interest credits and mortality and expense charges. A universal life insurance policy may also include other types of credits and charges. The term does not apply to policies, riders, group master policies, or individual certificates in connection with dividend accumulations, premium deposit funds, or other supplementary accounts.

(2) A universal life insurance policy issued in this state must include a provision requiring the policyowner to receive, at no cost, an annual report on the policy's status. The report must be sent within 3 months after the end of the reporting period. The report must include all of the following:

(a) The beginning and end of the current reporting period.

(b) The policy value at the end of the previous reporting period and at the end of the current reporting period.

(c) The total amounts that have been credited or debited to the policy value during the current reporting period, identified by type.

(d) The current death benefit at the end of the current reporting period on each life covered by the policy.

(e) The net cash surrender value of the policy as of the end of the current reporting period.

(f) The amount of outstanding loans, if any, as of the end of the current reporting period.

(g) For fixed premium policies, if, assuming guaranteed interest, mortality and expense loads, and continued scheduled premium payment, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to that effect.

(h) For flexible premium policies, if, assuming guaranteed interest and mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to that effect.

(i) For fixed premium or flexible premium policies, if, assuming guaranteed interest and mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until maturity of the contract, the projected date on which policy values will be insufficient to continue coverage in force.

(3) This section applies to all universal life insurance

policies except variable contracts as defined in s. 627.8015.

Section 3. Subsection (2) of section 627.6515, Florida Statutes, is amended to read:

627.6515 Out-of-state groups.—

(2) Except as otherwise provided in this part, this part does not apply to a group health insurance policy issued or delivered outside this state under which a resident of this state is provided coverage if:

(a) The policy is issued to an employee group the composition of which is substantially as described in s. 627.653; a labor union group or association group the composition of which is substantially as described in s. 627.654; an additional group the composition of which is substantially as described in s. 627.656; a group insured under a blanket health policy when the composition of the group is substantially in compliance with s. 627.659; a group insured under a franchise health policy when the composition of the group is substantially in compliance with s. 627.663; an association group to cover persons associated in any other common group, which common group is formed primarily for purposes other than providing insurance; a group that is established primarily for the purpose of providing group insurance, provided the benefits are reasonable in relation to the premiums charged thereunder and the issuance of the group policy has resulted, or will result, in economies of administration; or a group of insurance agents of an insurer, which insurer is the policyholder;

(b) Certificates evidencing coverage under the policy are issued to residents of this state and contain in contrasting

color and not less than 10-point type the following statement: "The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida"; and

(c) The policy provides the benefits specified in ss. 627.419, 627.6562, 627.6574, 627.6575, 627.6579, 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675, 627.6691, and 627.66911, and complies with the requirements of s. 627.66996.

(d) Applications for certificates of coverage offered to residents of this state must contain, in contrasting color and not less than 12-point type, the following statement on the same page as the applicant's signature:

"This policy is primarily governed by the laws of ...(insert state where the master policy is filed).... As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services."

This paragraph applies only to group certificates providing health insurance coverage which require individualized underwriting to determine coverage eligibility for an individual

or premium rates to be charged to an individual except for the following:

1. Policies issued to provide coverage to groups of persons all of whom are in the same or functionally related licensed professions, and providing coverage only to such licensed professionals, their employees, or their dependents;

2. Policies providing coverage to small employers as defined by s. 627.6699. Such policies shall be subject to, and governed by, the provisions of s. 627.6699;

3. Policies issued to a bona fide association, as defined by s. 627.6571(5), provided that there is a person or board acting as a fiduciary for the benefit of the members, and such association is not owned, controlled by, or otherwise associated with the insurance company; or

4. Any accidental death, accidental death and dismemberment, accident-only, vision-only, dental-only, hospital indemnity-only, hospital accident-only, cancer, specified disease, Medicare supplement, products that supplement Medicare, long-term care, or disability income insurance, or similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan, coinsurance, or deductibles or coverage issued as a supplement to workers' compensation or similar insurance, or automobile medical-payment insurance.

Section 4. Section 627.7293, Florida Statutes, is created to read:

627.7293 Towing and labor coverage requirements.—

(1) An automobile insurer that provides towing and labor

coverage as a filed claim shall provide the following language or substantially similar language on any web or electronic platform through which a towing or labor claim is made or verbally stated to the claimant if the claim is being made over the phone:

> Your auto insurance policy provides coverage for towing and labor. Use of this coverage requires a filing of a claim. Such claim filing will remain in your claims' history for use of future underwriting of any initial or renewal offer made by this insurer or any other insurer.

(2) The automobile insurer shall obtain the claimant's express consent before submitting a claim filed under the towing and labor coverage.

(3) This disclosure requirement provided under subsection (1) does not apply if the towing and labor claim is filed as part of a crash-related damage claim.

Section 5. Section 627.7431, Florida Statutes, is created to read:

627.7431 Payment of first-party claim.—

(1) For purposes of this section, the term:

(a) "Claim" means any first-party claim under an insurance policy providing coverage for a private passenger motor vehicle as defined in s. 627.732.

(b) "Factors beyond the control of the insurer" means:

1. Any of the following events that is the basis for the office issuing an order finding that such event renders all or

specified motor vehicle insurers reasonably unable to meet the requirements of this section in specified locations and ordering that such insurer or insurers may have additional time, not exceeding 30 days, as specified by the office, to comply with the requirements of this section: a state of emergency declared by the Governor under s. 252.36, a breach of security that must be reported under s. 501.171(3), or an information technology issue.

2. Actions by the policyholder or the policyholder's representative which constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed, when such actions reasonably prevent the insurer from complying with any requirement of this section.

3. Actions by any repair company which constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed, when such actions reasonably prevent the insurer from complying with any requirement of this section.

4. Inaccessibility to or delay in the arrival of parts necessary for the repair of the vehicle.

(2) Within 60 days after an insurer receives notice of an initial, reopened, or supplemental first-party physical damage insurance claim from a policyholder, the insurer shall pay or deny such claim or a portion of the claim unless the failure to pay is caused by factors beyond the control of the insurer. The insurer shall provide a reasonable explanation in writing to the policyholder of the basis in the insurance policy, in relation to the facts or applicable law, for the payment, denial, or partial denial of a claim. If the insurer's claim payment is

less than that specified in any insurer's detailed estimate of the amount of the loss, the insurer must provide a reasonable explanation in writing of the difference to the policyholder. Any payment of an initial or supplemental claim or portion of such claim made 60 days after the insurer receives notice of the claim, or made after the expiration of any additional timeframe provided to pay or deny a claim or a portion of a claim made pursuant to an order of the office finding factors beyond the control of the insurer, whichever is later, bears interest at the rate set forth in s. 55.03. Interest begins to accrue from the date the insurer receives notice of the claim. This subsection may not be waived, voided, or nullified by the terms of the insurance policy. If there is a right to prejudgment interest, the insured must select whether to receive prejudgment interest or interest under this subsection. Interest is payable when the claim or portion of the claim is paid. Failure to comply with this subsection constitutes a violation of this code. However, failure to comply with this subsection does not form the sole basis for a private cause of action.

(3) This section applies to surplus lines insurers and surplus lines insurance authorized under ss. 626.913-626.937 providing personal automobile coverage.

(4) This section does not apply to any of the following claims:

(a) Any claims covered under an insurance policy providing coverage for commercial motor vehicles as defined in s. 627.732.

(b) Any portion of a claim covered under an insurance policy covering private passenger motor vehicles if the portion of the claim is based on coverage for:

1. Personal injury protection;

2. Property damage liability;

3. Bodily injury;

4. Uninsured motorists or underinsured motorists; or

5. Medical payments.

(5) The requirements of this section are tolled:

(a) During the pendency of any mediation proceeding under s. 627.745 or any alternative dispute resolution proceeding provided for in the insurance contract. The tolling period ends upon the end of the mediation or alternative dispute resolution proceeding.

(b) Upon the failure of a policyholder or a representative of the policyholder to provide material claims information requested by the insurer within 10 days after the request was received. The tolling period ends upon the insurer's receipt of the requested information. Tolling under this paragraph applies only to requests sent by the insurer to the policyholder or to a representative of the policyholder at least 15 days before the insurer is required to pay or deny the claim or a portion of the claim under subsection (2).

Section 6. This act shall take effect July 1, 2025.