



# FLORIDA INSURANCE REPORT

RADEY THOMAS YON & CLARK

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Keeping You Informed About Florida

## Early Session Brings Fast Start to 2012

By: Travis Miller

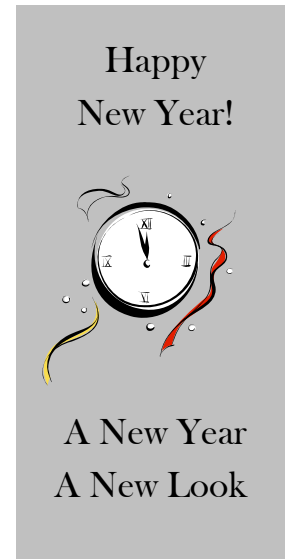
With the holiday season just barely behind us, the new year will get off to a fast start in Florida as our legislative session starts. This is about two months earlier than usual. Every ten years the legislature must deal with reapportionment, which necessitates an earlier start to the session. It's hard to think about the second week of January being "late," but with the legislature's rules relating to the number of bills legislators may offer and the deadlines for filing those bills, anyone waiting for the effects of the New Year's Eve cham-

pagne to wear off before getting engaged in this year's session might end up late to the party.

We routinely see property insurance issues dominating legislative sessions in Florida. However, that might not be the case in 2012. After significant property insurance legislation in 2011 in the form of Senate Bill 408, there are fewer property insurance items on the agenda. One of the most significant items might deal with the Florida Hurricane Catastrophe

Fund. The FHCF and proponents of legislative change believe the size of the FHCF should be reduced to better enable it to meet the reimbursement obligations it has promised. Others, however, believe that early estimates of the rate impact of FHCF reduction proposals is understated—the bill will result in higher reinsurance costs and therefore higher rates at levels beyond what policymakers are likely to consider acceptable. In addition, the bill

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## New Changes Regarding Appointments in Florida

By: David Yon

The Department of Financial Services, Division of Agent and Agency Services, released information on new changes beginning January 18, 2012, on the appointments and renewals of licensees in Florida. The Department says its focus is on the timeliness and accuracy of information. The changes assess late fees for failing to meet specified dead-

lines for notification of appointments.

**Accuracy of Information** - An appointing entity will be not able to appoint or renew a licensee or appointee that has an inaccurate address on file with the Department. This practice is already in place for original appointments, but will now apply to renewals starting on January 18, 2012. The types of addresses included in

this policy are email, home, business and mailing addresses.

**Late Fees** - Also beginning January 18, 2012, a statutory \$250 late fee will be assessed in addition to the appointment fee for late submissions of original appointments. A late appointment is defined as

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## Get to Know...

By: Karen Asher-Cohen

**JIM PAFFORD** - Jim is the Director of Market Conduct Investigations at the Florida Office of Insurance Regulation. Jim grew up in Monticello, Florida. He attended North Florida Junior College in Madison, FL, and then graduated from Auburn University with a B.S. in Accounting. He first worked in his family's fuel distribution business. Jim came to the (then) Department of Insurance in 1990 to work in the Division of Rehabilitation and Liquidation as an Accountant III. He started managing receivership estates and within three years, he was promoted to Director of Accounting. In 1998, Jim was asked to run the Administrative Supervision section for the Division of Insurer Services and in 1999 he became the Chief Examiner for the Life & Health Solvency bureau. Jim then took a break from the Department, until that fateful day in March, 2009, when Robin Westcott lured him back to OIR to work in Property & Casualty Financial Exams. Two years later, Belinda Miller (now General Counsel) asked Jim to accept the position of Director of Market Conduct Investigations.

Recently, I sat down with Jim and asked the following questions.

### *Coming from Receivership, is this a very different role for you?*

Coming from Receivership, I have skills in different areas. Anyone who worked in Receivership was able to see the results of when a company fails and when regulation fails. Importantly, I gained intuition about companies and solvency. Coming from that background, I understand the importance of solvency and the benefits of strong regulation. But market conduct is different from everything else. While it

is related to solvency and finance, there are many other issues as well. The whole area of market conduct was new to me and quite a challenge. I am very fortunate to have a lot of really smart, good people working here.

### *What are your goals as Director of Market Conduct?*

I see Market Conduct as an arm of Legal Services, as Legal's research and enforcement arm. I am working on that.

### *Will Market Conduct concentrate on scheduled exams or target exams, or a combination of both?*

The goal set by the Commissioner is to move away from scheduled exams. Of course, a few types of exams are still scheduled for both life and health, and property and casualty. More exams will be based on cause, maybe from a consumer complaint or improper advertising, for example. Market conduct can also be used for financial examinations. The statutes are quite broad and it is easy for our section to move into that area due to our financial and contracting expertise.

### *How has insurance regulation changed since you started?*

One change is that we're trying to move away from regularly scheduled exams, which theoretically could result in fewer costs to companies. However, it is a complicated issue. Ideally, market conduct exams should be an early detection mechanism for OIR. It is difficult to have early detection if we don't get into the companies. To really know what it is going on, you need an examiner in the company. Certain information can only

be obtained on-site and you can't really read market conduct trends from just a statistical analysis of a company. Market conduct is not just hard numbers, like solvency. Market analysis is performed from looking at trends with statistical input.

### *What do you see as your focus in 2012?*

Our biggest issue right now is the life exams being conducted all across the country regarding unclaimed property and policies. Florida participates to a great extent in the multi-state exams. And while we hire contractors to do the on-site examinations, we still write the market conduct examination reports and findings.

### *Do you expect to conduct more hearings of the life insurance industry?*

More hearings are possible. Settlement with the target companies is a key part of the process and if the companies are willing to settle without a hearing, we would be willing to sit down with them. Life claims are a very interesting issue. We have reached a settlement with one company [John Hancock] and we expect more this year.

### *What are your biggest challenges going forward?*

Like everyone else, we don't have enough expense money. We need more qualified, capable, smart people in house. It's a challenge to manage all the outside examiner contracts and produce a quality work product without a team on the ground at a company. This is especially true because we continue to write all the reports and findings in-house.

*Continued at Top of Next Page*

**Does the Legislative Session affect your section?**

Only on the periphery. There is less impact on market conduct because so few statutes apply just to us. But we get pulled in for advice or suggestions during session, just like everyone else. This time of year, it's all hands on deck.

***What advice would you give a company facing a market conduct examination?***

There will always be questions and challenges. I would advise a company to develop a compliant relationship with their examiner, because it will end up costing them a lot less in the long run. We are open to questions and I would rather have a dialog with a company at the beginning of the process to clear up any issues, because it's always best to give the examiner what they asked for up front.

***What's the best part of your job?***

Every day is a new day with a different set of challenges. My day is never what I planned for myself and or what I put on an agenda. It's also the worst part of the job. Frequently, at the end of the day, you see that you didn't accomplish any of the things on your list. But for better or worse, it's never boring.

***How do you get away from it all?***

I can retreat on the weekends and I always love the beach.



*Jim Pafford*

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might only compound the disparity between the private market and Citizens Property Insurance Corporation, compounding problems that are causing Citizens to grow at an alarming rate.

Speaking of Citizens, we can expect to see proposals designed to stem the drastic increases in its policy count. This may include reducing its coverages, increasing its rates, and other underwriting or procedural changes.

The most contentious insurance issue of the 2012 session might be PIP reform. Although many parties point to problems in the PIP market, few agree on solutions. Ideas range from scrapping the PIP system to leaving it alone, and everything in between. The divergence of views on this issue dictates that PIP might go down to the wire in this year's session.

We'll see our share of other issues as well. Proposals are surfacing in the areas of workers' compensation and health insurance, and this session like most will have a bill on agent and agency regulation. We'll write about this year's developments in future

editions of the Florida Insurance Report, and we provide more frequent updates in the Legislative and Blog areas of our website at [www.radevlaw.com](http://www.radevlaw.com).

**2012 Session Dates**

**January 10, 2012 - Regular Session convenes/deadline for filing bills for introduction**

**February 28, 2012 - 50th day—last day for regularly scheduled committee meetings**

**March 5, 2012 - All bills are immediately certified**

**Conference Committee Reports require only one reading**

**Motion to reconsider made and considered the same day**

**March 9, 2012 - 60th day—last day of Regular Session**

## Citizens to Keep Emergency Assessment at One Percent

By: Travis Miller

Citizens Property Insurance Corporation recently voted to keep the emergency assessment percentage at 1 percent for 2012. This is the emergency assessment being collected from policyholders to retire bonds Citizens issued in response to losses from the 2004 and 2005 hurricane seasons.

Last year, Citizens reduced the emergency assessment from 1.4 percent to 1 percent. It is required to review the assessment each year to ensure that enough funds are being generated to retire the debt, but also that excess funds are not being generated. Even if Citizens is able to slightly reduce the assessment percentage, it might choose not to do so if the administrative burden and costs to Citizens and the industry outweighs the reduction. In Citizens' current situation, it believes the assessment is generating slightly more than will be needed to retire the bonds. However, rather than further reducing the assessment percentage, Citizens has opted to retain flexibility and avoid the administrative costs associated with making a small change.

The emergency assessments are supposed to end by mid-2016, but at the current pace of collection they could end a year earlier.

## DFS Answers Question of Referral Arrangements

By: David Yon

The Department of Financial Services has issued a Declaratory Statement pertaining to whether a referral arrangement between a law firm and an insurance agency violated the insurance code. Under the arrangement the agency agreed to pay to the lawyer an annual flat fee for any and all legal clients referred by the lawyer to the agent for the potential purchase of insurance policies. The payment of the fee was not dependent in any way on whether insurance was actually purchased.

The Department concluded, based on the facts presented, that the transaction would not violate any provisions of the insurance code. In reaching its conclusion, the Department commented on the applicability of sections 626.9541(1)(h) (unlawful rebates), 626.753(1) (commission sharing) and 626.112(8) (referral fees).

After setting out the language in section 626.9541(1)(h), the order finds the arrangement was not an unlawful rebate or inducement and states:

*By its own language, Section 626.9541(1)(h)1, Florida Statutes, applies to the giver or payer of a rebate or unlawful inducement. It prohibits any person from, 'paying allowing, giving or offering to pay, allow or give... an inducement to an insurance contract.' Except as to title insurance, provided for in subparagraph (1)(h)3.a.,*

*which is inapplicable here, Section 626.9541(1)(h), Florida Statutes, does not apply to the recipient of a rebate or unlawful inducement. According to the Petition, the proposed referral agreement provides for Michelson to pay the referral fee to Bogen. This section should not be interpreted to prohibit payment from Michelson (agent) to Bogen (lawyer) unless the payment is intended as an unlawful inducement.*

Next the order found the arrangement did not constitute unlawful commission sharing, stating in paragraph 10:

*Section 626.753(1), Florida Statutes, provides that, 'An agent may divide or share in commissions only with other agents appointed and licensed to write the same kind or kinds of insurance.' This section would not prohibit payment of a referral fee from Michelson to Bogen because the payment is not dependent upon the purchase of an insurance policy which would generate a commission payment to the agent. As indicated in the petition, the referral fee 'will not be dependent in any sense' upon the purchase of an insurance policy.*

Finally the order states the arrangement was not an illegal payment of a referral fee. Paragraph 11 provides:

*Section 626.112(8), Florida Statutes, also prohibits referral fees to be paid by licensed agents to unlicensed persons, but only if the fee is dependent upon the purchase of an insurance policy. Section 626.112(8), Florida Statutes, provides:*

*No insurance agent, insurance agency, or other person licensed under the Insurance Code may pay any fee or other consideration to an unlicensed person other than an insurance agency for the referral of prospective purchasers to an insurance agent which is in any dependent upon whether the referral results in the purchase of an insurance product.*

The order specifically noted the Department could not and was not addressing whether the arrangement was permitted by the Florida Bar rules or whether the plan might be legal expense insurance subject to regulation under chapter 642.017, Florida Statutes. The plan also includes a "legal plan to all accounting customers of agent." The Petition asserts the legal plan was exempt from the provisions of Chapter 642, Legal Expense Insurance. The Declaratory Statement did not accept this assertion, stating instead the Petition has not set forth sufficient facts for the agency to conclude the plan was exempt.

# Florida Insurance Consumer Advocate Issues Final PIP Report

By: Karen Asher-Cohen

Robin Westcott, the Florida Insurance Consumer Advocate, issued her Report on Florida Motor Vehicle No-Fault Insurance (Personal Injury Protection). The Report is a result of the three meetings held by the PIP Working Group, which Westcott created to study all aspects of the PIP system. The Working Group, comprised of legislative and executive branch representatives, insurance and medical industry members, and consumer advocacy groups, heard presentations and collected data and information from many varied sources. The purpose of the report, according to Westcott, is to “help foster policy discussions and reforms to more effectively combat fraud and abuse in the system,” which has caused a significant increase in PIP premiums and a “fraud tax” of nearly \$1 billion on Florida consumers.

In her Conclusion, Westcott questions the continuing viability

of the PIP coverage: “In the last two years, fraud and abuse has so permeated this coverage that the initial value of such a system is, at best, diluted and now threatens to be prohibitively expensive for Floridians. At best, we are at a crossroads as to the costs versus the benefits to consumers of a \$10,000 PIP coverage limit.” She also suggests to legislators that they consider the following policy areas during the 2012 legislative session, which started January 10, 2012, in Tallahassee: providers and venue; over-utilization; electronic claims filing; and litigation costs. Moreover, should reforms be adopted by the 2012 Legislature, Westcott harkens back to her OIR roots and concludes by saying that “it is imperative that insurance companies be held accountable for passing savings on to consumers through a required rate filing within 12 months of enacted reforms, and every six months thereafter.”

In a related note, Robin Westcott hired Brian Deffenbaugh as Senior Counsel for the Insurance Consumer Advocate’s Office. Deffenbaugh has over 20 years experience in the Florida Legislature as counsel and Staff Director for insurance-related committees in the House and Senate. Most recently, Brian served as Ethics Counsel for Citizens Property Insurance Corporation. “Brian will be another strong voice fighting for and protecting Florida’s insurance consumers,” said ICA Robin Westcott. “With many issues facing Florida’s consumers and the insurance market, there is no better person to supplement our already strong team of advocates.”\*

A copy of the Report can be found on our website under Insurance/Resources.

*\*Editor’s Note: RTYC Associate Angela Deffenbaugh Miles agrees that Brian will do a great job.*

“In the last two years, fraud and abuse has so permeated this coverage that the initial value of such a system is, at best, diluted and now threatens to be prohibitively expensive for Floridians. At best, we are at a crossroads as to the costs versus the benefits to consumers of a \$10,000 PIP coverage limit.”

Robin Westcott

## New Changes - Continued from Page 1

any appointment that has a requested effective date more than 45 days before the submittal date. Renewals that are late will be assessed a \$25 late fee in addition to the renewal fee. These late fees must be paid by the entity making the appointments and cannot be charged back to the licensee.

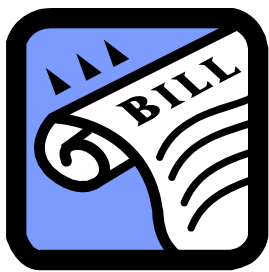
### Appointment Renewal Timeline/

Notification Process - Additionally, on January 18, 2012, the Department will begin sending e-mail notifications to the appointing entities of those licensees that

are up for renewal. The first such e-mail will be generated 90 days before the licensee is up for renewal. The second will be sent on the first day of the renewal month for each licensee at which time the appointing entity can access the e-Appoint system and make payments. The third e-mail will be sent on the first day of the month following the expiration date of a renewal advising that payment has not been received and that late fees have been assessed. The invoice will be available for 45 more days for payment otherwise it will be cancelled.

If the renewal is not made after this 45-day period, the appointment is cancelled and the appointing entity and the licensee will receive an e-mail notifying them that the appointment has been cancelled for non-renewal and outlining the process for reappointment and the late fee.

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## Federal Government Denies OIR's Request to Delay Implementation Of Health Rules

By: *Karen Asher-Cohen*

The U.S. Department of Health and Human Services, on December 15, 2011, denied Commissioner McCarty's request to delay the new Patient Protection and Affordable Care Act's requirement that health insurers implement an 80% medical loss ratio ("MLR") on individual and small group health insurance policies. In other words, health insurers must use 80 cents of every dollar of premium money collected to pay for medical services or health care quality improvement, as opposed to administrative costs. Insurers that do not meet that standard will be required to issue rebates to their policyholders. HHS has denied waiver applications from eight states, including Florida, and has approved six state waivers to date.

Commissioner McCarty had asked HHS to waive the new requirement for three years, and allow Florida instead to implement a medical loss ratio adjustment of 68 percent, 72 percent, and 76 percent for the years 2011, 2012, and 2013, respectively. In its request, the OIR claimed that without such a waiver, Florida's individual health insurance market would be destabilized. McCarty also currently serves as the President of the NAIC.

On December 30, 2011, Commissioner McCarty sent a letter to HHS requesting reconsideration of its earlier denial, stating: "Failure to obtain the requested adjustment will cause permanent, irreparable harm to our market and the distribution channel for health products and

services." McCarty went on to say: "Since the passage of the Affordable Care Act, Florida has not received any applications for new entrants into the individual market, and no new issuers appear to be interested in expanding into this market. Finally, perhaps our most important concern is the impact the Affordable Care Act and the MLR ratios will have on the agency workforce."

On January 6, 2012, Deputy Commissioner Michelle Robleto sent a follow-up letter to HHS with additional documentation. In her letter, Robleto stated: "The documentation includes numerous letters from the agent community discussing how the immediate implementation of the MLR has negatively affected their businesses in Florida. In addition, we also have letters from several insurers operating in our state showing how the immediate implementation of the MLR will destabilize the individual health insurance marketplace."

On a related note, on December 28, 2011, McCarty issued Informational Memorandum #OIR-11-09M to notify all Florida health insurers and HMO's that for purposes of calculating and reporting the MLR under the Affordable Care Act, the Florida law would be pre-empted by the Federal definition of a "small employer." The federal definition of a small employer is having 1 to 100 employees, whereas Florida defines a small employer as having 1 to 50 employees.

## Follow 2012 Insurance Bills on Our Legislative Page

By: *Travis Miller*

Although it seems to be here too quickly, the 2012 legislative session is upon us. We'll be following all of the bills of interest throughout the legislative session and updating their status on the Legislative Updates page of our website. This page can be accessed through the menu bar on our home page at [www.radevlaw.com](http://www.radevlaw.com), or it can be bookmarked directly at [www.radevlaw.com/legislative-updates](http://www.radevlaw.com/legislative-updates). If you're having trouble wading through which bills apply to insurance this year, we've got them listed for you by bill number. New for 2012, we have expanded the firm's capacity for legislative monitoring and advocacy, so we'll be on top of things from start to finish.

## Appellate Update

By: Tom Crabb



### Delayed Payment Of Appraisal Award By Insurer Does Not Excuse Insured From Repairing Property Before Receiving Replacement Cost Value

*Florida Ins. Guar. Ass'n v. Somerset Homeowners Ass'n, Inc.*, Case No. 4D10-4157 (Fla. 4th DCA 2011). The Somerset condominiums suffered extensive damage during two hurricanes. The original insurer of the condominiums, and later FIGA following the insolvency of the original carrier, both made partial payments on the claims. Somerset then filed suit against FIGA seeking more money. While the suit was pending the parties agreed to submit the matter to an appraisal as provided by the policy. Ultimately, an umpire set the replacement cost value of the loss at \$12.6 million and the actual cash value of the loss at \$11.6 million. The \$1 million difference represented depreciation - an amount withheld until the insured actually repaired or replaced the damaged property. The policy provided that replacement cost value would not be paid until repairs were made, which had to be done "as soon as reasonably possible after the loss or damage."

After FIGA did not timely pay the appraisal award, a trial court entered a judgment confirming the entire \$12.6 million amount. This was despite the fact that the condominium had not yet made the repairs to the property. That is, the Court awarded the replacement cost value of \$12.6 million even though the insured had not yet complied with the policy condition entitling it to the replacement cost as opposed to actual cash value. The insurer appealed, disputing the \$1 million difference between replacement cost and actual cash value. On appeal, the insured argued "prevention of performance" - that it was excused from per-

forming its contractual obligation to repair the property because the insurer had delayed payment of the appraisal award, preventing the insured from making the repairs to the property. On December 21, 2011, the Fourth District disagreed with the insured and held that the replacement cost value payment was improper and therefore had to be reduced by \$1 million back to the actual cash value. In doing so, the Court refused to rewrite the insurance contract under the insured's theory that it would be too costly for it to comply with the policy by promptly paying for the repairs without the appraisal money. The Court said the policy was clear and unambiguous and accordingly "should be enforced according to its terms."

### For An Insured To Obtain Attorney's Fees In A Coverage Lawsuit, Successfully Defending A Counterclaim From The Insurer Is Sufficient, Even If No Recovery Results And No Finding Of Coverage Is Made

*Rodriguez v. GEICO*, Case No. 4D10-4617 (Fla. 4th DCA 2011). An insured was involved in a car accident and ultimately got into a dispute with his insurer over the amount of the damage. The insurer paid more money yet the insured was still unsatisfied and ultimately filed suit seeking still more money on the claim. The insurer filed a counterclaim against the insured for fraud and sought refund of the monies already paid to the insured. Following motions for summary judgment by both parties, the county court entered judgment in favor of the insurer on the insured's coverage claim (i.e., no more money for repairs was due from the insurer) and entered judgment in favor of the insured on the insurer's counterclaim (i.e., the insured had not engaged in fraud). Both parties moved for attorney's fees - the insured as a prevailing party

under section 627.428 (providing for attorney's fees for an insured who obtains a judgment against its insurer), and the insurer because it had earlier made a \$100.00 offer for settlement which was rejected by the insured, entitling it to fees under section 768.79. The county court awarded the insurer \$168,000 in attorney's fees, but nothing to the insured, reasoning that the insured had not made a monetary recovery and no coverage was found to exist and there was thus no basis for the insured to recover its fees under section 627.428. The insured then appealed the county court's decision to the circuit court sitting in an appellate capacity. The circuit court affirmed the county court, using a "prevailing party" test - the insured was not entitled to attorney's fees because he had not prevailed "on the significant issues before the court."

The insured then sought "second tier" appellate review by the Fourth District Court of Appeal, which reversed both the lower courts and awarded fees to the insured. The Fourth District held that it was error to fail to award the insured fees under 627.428, which only requires the insured to "obtain a judgment in his favor in order to be entitled to an award of attorneys' fees." By prevailing on the insurer's counterclaim for fraud, the insured had obtained a judgment in his favor against the insurer. Accordingly, the case was remanded back to the trial court to enter a fee award to the insured and offset that with the amount awarded to the insurer, which was upheld.

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