Chapter Ins 3

CASUALTY INSURANCE

Ins 3.01 Accumulation benefit riders attached to health and accident policies
Ins 3.02 Automobile fleets, vehicles not included in
Ins 3.04 Dividends not deducted from premiums in computing loss reserves
Ins 3.07 Rules in chapter Ins 4, FIRE AND ALLIED LINES INSURANCE, applicable to casualty insurance
Ins 3.09 Mortgage guaranty insurance
Ins 3.11 Multiple peril insurance contracts
Ins 3.12 Membership fees and policy fees
Ins 3.13 Individual accident and sickness insurance
Ins 3.14 Group accident and sickness insurance
Ins 3.15 Blanket accident and sickness insurance
Ins 3.17 Reserves for accident and sickness policies
Ins 3.18 Total consideration for accident and sickness insurance policies
Ins 3.19 Group accident and sickness insurance insuring debtors of a creditor
Ins 3.20 Substandard risk automobile physical damage insurance for financed vehicles
Ins 3.21 "In the same industry", definition of
Ins 3.22 Bail bond insurance
Ins 3.23 Franchise accident and sickness insurance
Ins 3.25 Credit life insurance and credit accident and sickness insurance
Ins 3.26 Unfair trade practices in credit life and credit accident and sickness insurance
Ins 3.27 Advertisements of and deceptive practices in accident and sickness insurance
Ins 3.28 Solicitation, underwriting and claims practices in individual and franchise accident and sickness insurance
Ins 3.29 Replacement of accident and sickness insurance
Ins 3.30 Change of beneficiary and related provisions in accident and sickness insurance policies
Ins 3.31 Eligibility for and solicitation, underwriting and claims practices in group, blanket and group type accident and sickness insurance
Ins 3.32 Title insurance; prohibited practices
Ins 3.35 Wisconsin health care liability insurance plan
Ins 3.36 Statistical reports - health professional liability insurance
Ins 3.37 Future medical expense funds

Ins 3.01 Accumulation benefit riders attached to health and accident policies. Except where such rider is used only on a policy replacing the company's own policy, and so recites, no rider providing for accumulations of benefits will be approved for use upon any policy of health and accident insurance, whether it is proposed to issue such rider with or without an additional premium. Such rider operates as an aid to twisting the policies of another company in such manner as to make its use a direct encouragement of this practice.

Ins 3.02 Automobile fleets, vehicles not included in. Individually owned motor vehicles cannot be included or covered by fleet rates. The determining factor for inclusion under fleet coverage must be ownership and not management or use.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may not be deducted from the earned premiums in computing loss reserves under section 623.04, Wis. Stats.

History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.07 Rules in chapter Ins 4, fire and allied lines insurance, applicable to casualty insurance. The following captioned rules

under chapter Ins 4, FIRE AND ALLIED LINES INSURANCE, are applicable to casualty insurance:

(1) Nonassessable policies of mutual companies.

(2) Policy, inspection and similar fees.

History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.09 Mortage guaranty insurance. (1) PURPOSE. This rule implements and interprets, including but not limited to, subsection 201.04 (19) of Ins 6.70 and sections 611.02, 611.24, 618.01, 618.21, 620.02 and 623.04, Wis. Stats., for the purpose of establishing minimum requirements for the transaction of mortgage guaranty insurance.

(2) SCOPE. This rule shall apply to the underwriting, investment, marketing, rating, accounting and reserving activities of insurers which write the type of insurance authorized by subsection 201.04 (19) of Ins 6.70.

(3) DEFINITIONS. (a) Mortgage guaranty insurance is that kind of insurance authorized by subsection 201.04 (19) of Ins 6.70, and includes the guarantee of the payment of rentals under leases of real estate in which the lease extends for 3 years or longer.

(b) As used in this rule, "person" means any individual, corporation, association, partnership or any other legal entity.

(4) DISCRIMINATION. No mortgage guaranty insurer may discriminate in the issuance or extension of mortgage guaranty insurance on the basis of the applicant's sex, marital status, race, color, creed or national origin.

(5) LIMITATION OF TOTAL LIABILITY ASSUMED. A mortgage guaranty insurer shall not at any time have outstanding a total liability under its aggregate insurance policies, computed on the basis of its election to limit coverage and net of reinsurance assumed and of reinsurance ceded to an insurer authorized to transact such reinsurance in this state, exceeding 25 times the sum of its contingency reserve established under subsection (14) and its surplus as regards policyholders.

(6) LIMITATION ON INVESTMENT. A mortgage guaranty insurer shall not invest in notes or other evidences of indebtedness secured by mortgage or other lien upon real property. This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contracts of sale are acquired in the course of the good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurer, or in the good faith disposition of real property so acquired.

(7) LIMITATION ON ASSUMPTION OF RISKS. A mortgage guaranty insurer shall not insure loans secured by properties in a single or contiguous housing or commercial tract in excess of 10% of the insurer's admitted assets. A mortgage guaranty insurer shall not insure a loan secured by asingle risk in excess of 10% of the insurer's admitted assets. In determining the amount of such risk or risks, the insurer's liability shall be computed on the basis of its election to limit coverage and net of reinsurance ceded to an insurer authorized to

(ze) An advertisement shall not set out exceptions, reductions or limitations from a policy worded in a positive manner to imply that they are beneficial features such as describing a waiting period as a benefit builder. Words and phrases used to disclose exceptions, reductions or limitations shall fairly and accurately describe their negative features. The words "only" or "minimum" or similar words or phrases shall not be used to refer to exceptions, reductions or limitations.

(zf) An advertisement shall not state or imply, or use similar words or phrases to the effect, that because no insurance agent will call and no commissions will be paid to agents the policy is a low cost plan.

(zg) Devices such as a safe drivers' award and other such awards shall not be used in connection with an advertisement.

(zh) An advertisement which describes or offers to provide information concerning the federal Medicare program or any related government program or changes in such programs shall:

1. Include no reference to such program on the envelope, the reply envelope or to the address side of the reply postal card, if any,

2. Include on any page containing a reference to such program an equally prominent statement to the effect that in providing supplemental coverage the insurer and agent involved in the solicitation is not in any manner connected with such program,

3. Contain a statement that it is an advertisement for insurance or is intended to obtain insurance prospects,

4. Prominently identify the insurer or insurers which issues the coverage, and

5. Prominently state that any material or information offered will be delivered in person by a representative of the insurer, if such is the case.

(10) EXCEPTIONS, REDUCTIONS AND LIMITATIONS. (a) When an advertisement refers to any dollar amount of benefits payable, period of time for which any benefit is payable, cost of policy, specific policy benefit or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations (including waiting, elimination, probationary or similar periods and pre-existing condition exceptions) affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive subject to the following.

(b) An invitation to apply shall be subject to the disclosure requirements of this subsection.

(c) An invitation to inquire shall not be subject to the disclosure requirements of this subsection unless:

1. Such an advertisement mentions benefits, benefit periods or premiums for the purpose of doing more than identifying the policy or

2. Such an advertisement makes any reference to the policy's exceptions, reductions and limitations.

(d) A booklet, summary or explanation of coverage issued to insured persons shall be subject to the disclosure requirements of this subsection.

(e) An institutional advertisement shall not be subject to the disclosure requirements of this subsection.

(f) If the policy advertised does not provide immediate coverage for pre-existing conditions, an application or enrollment form contained in or included with an advertisement to be completed by the applicant and returned to the insurer shall contain a question or statement immediately preceding the applicant's signature line which summarizes the pre-existing condition provisions of the policy. The following are a suggested question and statement; however, an insurer shall use wording which is appropriate to the actual pre-existing condition provisions of the policy advertised: "Do you understand that the policy applied for will not pay benefits during the first - - - - - year(s) after the issue date for a disease or physical condition which you now have or have had in the past? Yes - - - - - -" or "I understand that the policy applied for will not pay benefits during the first - - - - - year(s) after the issue date for a disease or physical condition which I now have or have had in the past."

(g) An advertisement which is subject to the disclosure requirements of this subsection shall in negative terms disclose the extent to which any loss is not covered if the cause of the loss is a condition which exists prior to the effective date of the policy. The expression "pre-existing conditions" shall not be used unless appropriately defined.

(h) If a medical examination is required for a policy, an advertisement of such policy shall disclose such requirement.

(i) The exceptions, reductions and limitations referred to in this subsection shall include:

1. Those which are set out in the policy under captions referring to exceptions, reductions, limitations or exclusions or are otherwise designated as such, and

2. Those which are not so captioned or designated contained in other portions of the policy such as a benefit provision, definition or uniform provision.

(j) The following are examples of exceptions, reductions and limitations which generally *do* affect the basic policy provisions to such an extent that their absence would cause the advertisement to have the capacity and tendency to mislead or deceive.

1. War or act of war.

2. While in armed services.

3. Territorial restriction or coverage within United States and Canada.

4. Complete aviation exclusion.

5. Self-inflicted injury.

6. Injury inflicted by another person.

7. Time limitation on death, dismemberment or commencement of disability or medical treatment following an accident.

8. Pre-existing sickness or disease or other bodily infirmity.

9. Exclusion or reduction for loss due to specific diseases, classes of diseases or types of injuries.

10. Confinement restrictions in disability policies such as house confinement, bed confinement and confinement to the premises.

11. Waiting, elimination, probationary or similar periods.

12. Reduction in benefits because of age.

13. Any reduction in benefit during a period of disability.

14. Workmen's compensation or employers' liability law exclusion.

15. Occupational exclusion.

16. Violation of law.

17. Automatic benefit in lieu of another benefit.

3. That benefit payments are subject to an aggregate limit, if applicable.

(d) A printed advertisement describing a guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the term "guaranteed renewable":

1. The age to or term for which the form is guaranteed renewable, if other than lifetime,

2. The age or time at which the form's benefits are reduced, if applicable, (the age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or form for which the form is guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is guaranteed renewable)

3. That benefit payments are subject to an aggregate limit, if applicable, and

4. That the applicable premium rates may be changed.

(e) The foregoing limitations on the use of the term "non-cancellable" shall also apply to any synonymous term such as "not cancellable"; and the foregoing limitations on use of the term "guaranteed renewable" shall apply to any synonymous term such as "guaranteed continuable".

(26) FORM NUMBER. An advertisement which is an invitation to apply or an invitation to inquire and which is mass-produced shall be identified by a form number. The form number shall be sufficient to distinguish it from any other advertising form or any policy, application or other form used by the insurer.

(27) INSURER'S RESPONSIBILITY FOR ADVERTISEMENTS. (a) The content, form and method of dissemination of all advertisements, regardless of by whom designed, created, written, printed or used, shall be the responsibility of the insurer whose policy is advertised.

(b) An insurer shall require its agents and any other person or agency acting on its behalf in preparing advertisements to submit proposed advertisements to it for approval prior to use.

(28) INSURER'S ADVERTISING FILE. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its policies hereafter disseminated in this or any other state, whether or not licensed in such other state. With respect to group, blanket and franchise policies, all proposals prepared on the same printed form need not be included in the file; only typical examples of such proposals need be included. A notation shall be attached to each such advertisement in the file indicating the manner and extent of distribution and the form number of any policy, amendment, rider, or endorsement form advertised. A copy of the policy advertised, together with any amendment, rider or endorsement applicable thereto, shall be included in the file with each such advertisement. Such file shall be subject to regular and periodic inspection by the office of the commissioner of insurance. All such advertisements shall be maintained in such file for a period of 4 years or until the filing of the next regular examination report on the insurer, whichever is the longer period.

(29) INSURER'S CERTIFICATE OF COMPLIANCE. Each insurer which is required to file an annual statement and which is subject to the provisions of this rule shall file with the office of the commissioner of insurance, together with its annual statement, a certificate executed by an authorized officer of the insurer wherein it is stated that to the best of his knowledge, information and belief, the advertising file required by subsection (28) was properly maintained and the advertisements of the insurer's policies which were disseminated during the statement year complied or were made to comply in all respects with the provisions of the insurance laws of this state as implemented.

(30) PENALTY. Violations of this rule shall subject the violator to section 601.64, Wis. Stats.

(31) SEVERABILITY. The provisions of this rule are severable. If any provision of this rule is invalid, or if the application of the rule to any person or circumstance is invalid, such invalidity shall not affect other provisions or applications which can be given effect without the invalid provision or application.

(32) EFFECTIVE DATE. This rule shall apply to all advertisements used in this state after June 1, 1973.

History: Cr. Register, April, 1973, No. 208, eff. 6-1-73; am. (zb), (11) (c) 1. and (11) (e), Register, August, 1973, No.212, eff. 9-1-73; am. (5) (b) 1, Register, April, 1975, No. 232, eff. 5-1-75; emerg. am. (1), (2), (5) (c) and (m) 1, eff. 6-22-76; am. (1), (2), (5) (c) and (m) 1, Register, September, 1976, No. 249, eff. 10-1-76; cr. (9) (zh), Register, November, 1976, No. 251, eff. 12-1-76.

Ins 3.28 Solicitation, underwriting and claims practices in individual and franchise accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to promote the fair and equitable treatment of Wisconsin residents in the solicitation, underwriting and administration of accident and sickness insurance and of contracts issued by a plan subject to chapter 613, Wis. Stats. Sections of Wis. Stats. interpreted or implemented by this rule include but are not limited to sections 201.045 (3), 601.01 (3) (b), 611.20, and 618.12 (1), Wis. Stats.

(2) SCOPE. This rule applies to the solicitation, underwriting and administration of any insurance issued by any insurer or fraternal benefit society under subsection 201.04 of Ins 6.70 and sections 600.03 (34m) (d) and 632.94, Wis. Stats., except credit accident and sickness insurance under subsection 201.04 (4a) of Ins 6.70, and to any contract, other than one issued on a group or group type basis as defined in Wis. Adm. Code section Ins 6.51 (3), issued by a plan subject to chapter 613, Wis. Stats. For the purpose of this rule, references to insurer, policy, and insurance agent or representative, also apply to organizations or associations operating non-profit plans, contracts, and persons within the scope of the rule, respectively.

(3) APPLICATION FORM. An application form which becomes part of the insurance contract shall provide to the effect that statements made by the applicant in the application form regarding the general medical history or general health of a proposed insured person which require an opinion or the exercise of judgment are representations or are to the best of the applicant's knowledge and/or belief. Such form need not so provide with respect to statements regarding specifically named diseases, physical conditions, or types of medical consultation

or treatment. Such form shall not require the applicant to state that he has not withheld any information or concealed any facts in

Next page is numbered 105

(4) FILING REQUIRED. Each insurer doing business in this state in health professional liability insurance shall report the following information to the commissioner on or before March 1 of each year for the previous calendar year:

(a) The total number of insureds in Wisconsin within each rating class;

(b) The total amount of premium paid by the insureds in each rating class in Wisconsin;

(c) The total number of claims filed against insureds in each rating class in Wisconsin, the year in which the incident giving rise to each claim occurred, and the total number of such claims outstanding as of December 31;

(d) The total number and amount of claims paid by the insurer for insureds in each rating class in Wisconsin and the year in which the incident giving rise to each claim occurred;

(e) The number of lawsuits filed in Wisconsin against the insurer's insureds.

Note: In compiling this information, the instructions and procedures included in the Uniform Statistical Plan for Medical Professional Liability Insurance published by the Insurance Services Office shall be used to the extent applicable.

(5) EXCEPTIONS. Since the statistical information required by subsection (4) may not be readily available for calendar year 1975 in the detail specified: (a) All insurers shall submit on or before March 1, 1976, the basic Wisconsin information required by line 50 of Supplement "A" to Schedule T. Exhibit of Medical Malpractice Premiums Written During Current Year Allocated by States and Territories, a part of the Annual Statement for Fire and Casualty Companies listed in Wisconsin Administrative Code section Ins 7.01 (5) (a).

(b) An insurer who cannot file for calendar year 1975 the information required by subsection (4) based on the rating classes as defined in subsection (3) (b), shall file comparable information, based on the classifications used by that insurer for rating purposes during 1975, with sufficient explanation of the make-up of each rating class so that a proper combination of insurers doing business in Wisconsin may be made.

(c) Where detailed statistical information for calendar year 1975 is not available to an insurer by March 1, 1976, that insurer may, on or before March 1, 1976, file information based on estimated data, provided that detailed information is filed by June 1, 1976.

History: Emerg. cr. eff. 1-20-76; cr. Register, March, 1976, No. 243, eff. 4-1-76.

Ins 3.37 Future medical expense funds. (1) PURPOSE. This rule is intended to implement the provisions of section 655.015, Wis. Stats.

(2) SCOPE. This rule shall apply to all insurers, organizations and persons subject to chapter 655, Wis. Stats.

(3) DEFINITIONS. The following definitions shall apply in the administration of this rule:

(a) Fund shall mean the future medical expense fund, Fund No. 35 established by the bureau of financial operations, department of

administration under the provisions of sections 16.40 (5) and 16.41, Wis. Stats., to receive payments under section 655.015, Wis. Stats.

(b) Account shall mean that portion of such fund allocated specifically for the benefit of an injured person.

(c) Claimant shall mean the injured person, the individual legally responsible for any medical expenses sustained by the injured person, or the legally designated representative of such injured person.

(d) Medical expense shall mean those charges for medical services, nursing services, medical supplies, drugs or rehabilitation services which are necessary to the comfort and well being of the individual and incidental to the injury sustained.

(4) ADMINISTRATION. (a) When any settlement, award or judgement provides an amount in excess of $25,000 for future medical expense, the insurer, organization or person responsible for such payment shall forward to the commissioner the amount in excess of $25,000 within 30 days of any such settlement, award or judgment, and sHall enclose an appropriately executed copy of the document setting forth the terms under which the payment is to be made.

(b) The commissioner shall cause the monies so received to be paid into the future medical expense fund to be invested by the state of Wisconsin investment board under the authority of section 25.17 (1) (zm), Wis. Stats.

(c) Upon receipt of a request for reimbursement of medical expense of an injured person, the commissioner shall make appropriate investigation and inquiries to determine that the medical supplies or services provided are necessary and incidental to the injury sustained by the person for whom the account was established, and if satisfied that this is the case, shall pay these expenses out of the fund, using standard bookkeeping and accounting records and transactions established by sections 16.40 (5) and 16.41, Wis. Stats.

(d) The commissioner shall not less that once annually inform the claimant of the status of the account including the original amount, payments made, and the balance remaining.

(e) The commissioner shall maintain an individual file record of each account showing the original allocation, payments made, credits and the balance remaining. The commissioner shall further keep an account of the total balance in the fund and the allocations to each account.

(f) The commissioner shall credit each account with a pro rata share of interest earned, if any, based on the remaining value of each account at the time such interest earning is declared by the investment board, and using procedures established by that board.

(g) If the commissioner is satisfied that a third party provider of service has not been reimbursed for services or supplies rendered to the injured person, payments of any medical expense may be made jointly to the claimant and the provider of such medical supplies or services.

(h) Payment shall be made to the claimant for reasonable and necessary medical expense until such time as the allocated amount is

exhausted or until the injured person is deceased. Should the injured person become deceased and there is a balance in his account allocation, that amount shall be returned to the insurer, organization or person responsible for establishing the account.

History: Cr. Register, November, 1976, No. 251, eff. 12-1-76.