Chapter Ins 3

CASUALTY INSURANCE

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 a single 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

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.

Ins 3.38 Coverage of newborn infants. (1) PURPOSE. This section is intended to interpret and implement section 632.91, Wis. Stats.

(2) INTERPRETATION AND IMPLEMENTATION. (a) Coverage of each newborn infant is required under a disability insurance policy if 1. the policy provides coverage for another family member, in addition to the insured person, such as the insured's spouse or a child, and 2. the policy specifically indicates that children of the insured person are eligible for coverage under the policy.

(b) Coverage is required under any type of disability insurance policy as described in paragraph (a), including not only policies providing hospital, surgical or medical expense benefits, but also all other types of policies described in paragraph (a), including accident only and short term policies.

(c) The benefits to be provided are those provided by the policy and payable, under the stated conditions except for waiting periods, for children covered or eligible for coverage under the policy.

(d) Benefits are required from the moment of birth for covered occurrences, losses, services or expenses which result from an injury or sickness condition, including congenital defects and birth abnormalties of the newborn infant to the extent that such covered occurrences, losses, services or expenses would not have been necessary for the routine postnatal care of the newborn child in the absence of such injury or sickness. In addition, under a policy providing coverage for hospital confinement and/or in-hospital doctor's charges, hospital confinement from birth continuing beyond what would otherwise be required for a healthy baby (e.g. 5 days) as certified by the attending physician to be medically necessary will be considered as resulting from a sickness condition.

(e) If a disability insurance policy provides coverage for routine examinations and immunizations, such coverage is required for covered children from the moment of birth.

(f) An insurer may underwrite a newborn, applying the underwriting standards normally used with the disability insurance policy form involved, and charge a substandard premium, if necessary, based upon such underwriting standards and the substandard rating plan applicable to such policy form. The insurer shall not refuse initial coverage for the newborn if the applicable premium, if any, is paid as required by section 632.91 (3), Wis. Stats. Renewal coverage for a newborn shall not be refused except under a policy which permits individual termination of coverage and only as such policy's provisions permit.

(g) An insurer receiving an application, for a policy as described in paragraph (a) providing hospital and/or medical expense benefits, from a pregnant applicant or an applicant whose spouse is pregnant, may not issue such a policy to exclude or limit benefits for the expected child. Such a policy must be issued without such an

exclusion or limitation, or the application must be declined or postponed.

(h) Coverage is not required for the child born, after termination of the mother's coverage, to a female insured under family coverage who is provided extended coverage for pregnancy expenses incurred in connection with the birth of such child.

(i) A disability insurance policy described in paragraph (a) shall contain the substance of section 632.91 (1), (2), (3) and (4), Wis. Stats.

(j) Policies issued or renewed on or after November 8, 1975, and before May 5, 1976, shall be administered to comply with section 204.325, Wis. Stats., contained in chapter 98, Laws of 1975. Policies issued or renewed on or after May 5, 1976, and before June 1, 1976, shall be administered to comply with section 632.91, Wis. Stats., contained in chapter 224, Laws of 1975. Policies issued or renewed on or after June 1, 1976, shall be amended to comply with the requirements of section 632.91, Wis. Stats.

History: Cr. Register, February, 1977, No. 254, eff. 3-1-77; reprinted, Register, April, 1977, No. 256, to restore dropped text.

Ins 3.39 Standards for accident and sickness insurance sold to the Medicare eligible. (1) PURPOSE. (a) This rule establishes minimum requirements for accident and sickness insurance which may be sold to Medicare eligible persons as Medicare supplement coverage. A policy will be approved by the commissioner as a Medicare supplement if it contains the Designation and Caption that is appropriate for the level of coverage that policy provides. A policy that is designed or structured as a supplement to Medicare will be disapproved pursuant to section 631.20, Wis. Stats., if that policy does not meet the minimum requirements of any of the 4 classes of Medicare supplement insurance specified in this rule. Disclosure provisions are also established for other accident and sickness policies sold to Medicare eligible persons, because such policies frequently have been represented to, and purchased by, the Medicare eligible as supplements to Medicare.

(b) This rule seeks to reduce abuses and confusion associated with the sale of accident and sickness insurance to Medicare eligible persons by providing for clearly defined categories of Medicare supplement insurance and reasonable minimum levels of coverage for each category. The disclosure requirements and categories established are intended to provide to Medicare eligible persons guidelines that can be used to compare Medicare supplement insurance policies on the market and to aid them in the purchase of Medicare supplement coverage which is suitable for their needs. The rule is designed not only to improve the ability of the Medicare eligible consumer to make an informed choice when purchasing a Medicare supplement policy, but also to assure the Medicare eligible persons of this state that no policy will be approved by the Commissioner as a "Medicare supplement policy" unless it contains coverage which warrants the use of that label.

(c) Wisconsin statutes interpreted and implemented by this rule include but are not limited to sections 601.01 (3) (b), 631.20 (2), 631.23 and 628.34 (11).

(2) SCOPE. This rules applies to any individual accident and sickness insurance coverage which relates its benefits to Medicare, is designed to complement Medicare or is advertised or marketed as a supplement to Medicare, including hospital confinement indemnity coverage, nursing home coverage and specified disease coverage sold to the Medicare eligible, except that this rule shall not apply to conversion contracts issued as extensions or replacements for prior individual or group coverage.

(3) DEFINITIONS. For the purpose of this rule:

(a) *Medicare* means the hospital (part A) and medical (part B) insurance program established by title XVIII of the federal social security act of 1965, as amended.

(b) *Medicare eligible persons* include all persons who qualify for Medicare.

(c) *Medicare eligible expenses* are health care expenses of the type covered by Medicare, which may or may not be fully reimbursed by Medicare.

(d) *Medicare supplement coverage* means hospital, surgical or medical expense incurred and/or indemnity coverage which relates its coverage to eligibility for Medicare and which is designed to pay a specific deductible or co-payment requirement imposed under Medicare Parts A and/or B and which conforms to subsection (5) of this rule.

(e) *Hospital confinement indemnity coverage* means coverage as defined in Wisconsin Administrative Code section Ins 3.27 (4) (b) 6.

(f) *Specified disease coverage* means coverage which is limited to named or defined sickness conditions. Such coverage does not include dental or vision care coverage.

(g) *Nursing facility* means an institution which provides professional convalescent or rehabilitative services and which is licensed by the State of Wisconsin.

(h) *Outline of coverage* means an appropriately captioned or titled printed statement which meets the requirements of Wis. Adm. Code section Ins 3.27 (5) (1) and of subsection (4) (b) of this rule.

(i) Terms such as "skilled nursing facility" and "benefit period" used in this rule shall be as defined by Medicare. Terms used in Medicare supplement policies shall be worded no less favorably to the insured person than the corresponding Medicare definition.

(4) REQUIREMENTS. No accident and sickness insurance policy comprehended by this rule shall relate its coverage to Medicare or be structured, advertised or marketed as a supplement to Medicare unless:

(a) The policy:

1. Provides at a minimum the coverage set out in subsection (5);

2. Contains no pre-existing condition waiting period longer than 12 months except that a condition may be excluded from coverage by name or specific, non-generic description, effective on the date expenses are incurred; and

3. Contains in close conjunction on its first page the Designation, printed in capitals in a clear, contrasting ink in 18-point type of a style in general use, and the Caption, printed in a clear, contrasting ink in 12-point type of a style in general use, prescribed in subsection (5); and

4. Is plainly printed as to text in black or blue ink in type of a style in general use, the size of which is uniform and not less than 10-point with a lower-case unspaced alphabet length not less than 120-point.

(b) The outline of coverage for the policy:

1. Contains a clearly worded and organized chart or charts:

a. Summarizing the benefits provided by Medicare parts A and B;

b. Summarizing the Medicare supplement benefits provided by the policy; and

c. Indicating what Medicare eligible expenses remain uncovered by Medicare and the policy;

2. Complies with sections Ins 3.27 (5) (1) and Ins 3.27 (9) (u), (v) and (zh) 2 and 4;

3. Contains conspicuous statements:

a. That Medicare will not pay for charges it deems "unreasonable and unnecessary";

b. Unless the policy explicitly provides otherwise, that the policy will not pay for charges deemed "unreasonable and unnecessary" by Medicare;

c. Unless the policy explicitly provides otherwise, that the policy will not cover expenses outside of Medicare such as routine doctor examinations or eye glasses;

d. That the chart summarizing Medicare benefits only briefly describes the program; and

e. That the federal social security administration or its Medicare publications should be consulted for further details and limitations;

4. Contains in a close conjunction on its first page the Designation, printed in capitals in a clear, contrasting ink in 24-point type of a style in general use, and the Caption, printed in a clear, contrasting ink in 18-point type of a style in general use, prescribed in subsection (5); and

5. Is submitted to the commissioner for approval along with the policy form.

(5) AUTHORIZED DESIGNATIONS AND CAPTIONS AND MINIMUM COVERAGES. For a policy to meet the requirements of subsection (4), it must contain the authorized Designation, Caption and Minimum Coverage prescribed for one of the following categories of Medicare Supplement insurance.

(a) A MEDICARE SUPPLEMENT 1 policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 1

2. The following Caption: The State Insurance Commissioner's Office has established 4 categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). For an explanation of the differences between this "1" policy and policies in the other categories, consult the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do *not* buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below to at least a stated maximum of $22,500 per benefit period (inclusive of Medicare Parts A and B) or $15,000 per benefit period for Medicare Part A and $7,500 per calendar year for Medicare Part B. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare.

a. The following Medicare Part A eligible expenses:

1. Hospitalization, including 60 lifetime reserve days

2. Extended Care Services in a Skilled Nursing Facility

3. Home Health Care (post-hospital)

4. Blood

b. The following Medicare Part B eligible expenses:

1. Physician's services (except for routine physical examinations)

2. Home Health Care

3. Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical supplies such as splints and casts

v. Drugs and biologicals which cannot be self-administered

4. Outpatient Physical Therapy and Speech Pathology Services

5. Other Health Services and Supplies

i. Diagnostic x-rays and independent laboratory tests

ii. Ambulance

iii. Surgical dressings

iv. Prosthetic devices

v. Durable medical equipment

vi. Portable diagnostic x-ray services

6. Blood

c. Coverage shall be provided for at least 75% of prescription drug expenses and 50% of psychiatric treatment up to a separate lifetime maximum of at least $1,000.

(b) A MEDICARE SUPPLEMENT 2 policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 2

2. The following Caption: The State Insurance Commissioner's Office has established four categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). For an explanation of the differences between this "2" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do *not* buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below to at least a stated maximum of $15,000 per benefit period (inclusive of Medicare Parts A and B) or $10,000 per benefit period for Medicare Part A and $5,000 per calendar year for Medicare Part B. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare unless a minimum period is specified below.

a. The following Medicare Part A eligible expenses:

1. Hospitalization, including 60 lifetime reserve days

2. Extended Care Services in a Skilled Nursing Facility to the 100th day of confinement

3. Home Health Care (post-hospital)

b. The following Medicare Part B eligible expenses:

1. Physician's services (except for routine physical examinations)

2. Home Health Care

3. Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical supplies such as splints and casts

v. Drugs and biologicals which cannot be self-administered

4. Outpatient Physical Therapy and Speech Pathology Services

5. Other Health Services and Supplies

i. Diagnostic x-rays and independent laboratory tests

ii. Ambulance

iii. Surgical dressings

(c) A MEDICARE SUPPLEMENT 3 policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 3

2. The following Caption: The State Insurance Commissioner's Office has established four categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). For an explanation of the differences between this "3" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do *not* buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below to at least a stated maximum of $6,500 per benefit period (inclusive of Medicare Parts A and B) or $5,000 per benefit period for Medicare Part A and $1,500 per calendar year for Medicare Part B. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare unless a minimum period is specified below.

a. The following Medicare Part A eligible expenses:

1. Hospitalization to the 90th day of confinement

2. Co-payment for each of 30 lifetime reserve days of hospital confinement

3. Extended Care Services in a Skilled Nursing Facility to the 100th day of confinement

b. The following Medicare Part B eligible expenses:

1. Physician's services (except for routine physical examinations)

2. Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical supplies such as splints and casts

3. Ambulance

(d) A MEDICARE SUPPLEMENT 4-A policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 4-A - LIMITED MEDICARE PART A SUPPLEMENT ONLY.

2. The following Caption: This policy provides substantial coverage for hospitalization and other Medicare Part A expenses only. It will *not* pay for doctor's bills or any other Medicare Part B expenses. The State Insurance Commissioner's Office has established four categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). For an explanation of the differences between this

"4-A" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do *not* buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Part A Medicare eligible expenses listed below to at least a stated maximum of $15,000 per benefit period. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare. This policy shall not contain any coverage to Supplement Medicare Part B.

a. The following Medicare Part A eligible expenses:

1. Hospitalization, including 60 lifetime reserve days

2. Extended Care Services in a Skilled Nursing Facility

3. Home Health Care (post-hospital)

4. Blood

(e) A MEDICARE SUPPLEMENT 4-B policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 4-B - LIMITED BENEFIT PART B SUPPLEMENT ONLY.

2. The following Caption: This policy provides supplemental coverage for the doctor's bill and other medical expenses under Medicare Part B only. It will *not* pay for hospitalization, a nursing home stay or other Medicare Part A expenses. The State Insurance Commissioner's Office has established four categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). For an explanation of the differences between this "4-B" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do *not* buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Part B Medicare eligible expenses listed below to at least a stated maximum of $7,500 per calendar year. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare. This policy shall not contain any coverage to supplement Medicare Part A. A deductible up to $500 of Medicare eligible expenses per calendar year may be included.

a. The following Medicare Part B eligible expenses:

1. Physicians Services (except for routine physical examinations)

2. Home Health Care

3. Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical Supplies such as splints and casts

v. Drugs and biologicals which cannot be self-administered

4. Outpatient Physical Therapy and Speech Pathology Services

5. Other Health Services and Supplies

i. Diagnostic x-rays and independent laboratory tests

ii. Ambulance

iii. Surgical dressings

iv. Prosthetic devices

v. Durable medical equipment

vi. Portable diagnostic x-ray services

6. Blood

(6) PERMISSIBLE EXCLUSIONS AND LIMITATIONS: The coverages set out in subsection (5) may:

(a) exclude expenses for which the insured is compensated by Medicare.

(b) exclude coverage for the initial deductibles for Medicare Parts A and B.

(c) include any exclusion, limitation or conditions contained in Medicare.

(d) contain an appropriate provision relating to the effect of other insurance on claims.

(e) except for a Medicare Supplement 1 policy, limit coverage of psychiatric treatment to 50% of the reasonable and necessary charges and to a lifetime benefit of $500.

(7) NURSING HOME COVERAGE. (a) Any Medicare Supplement policy comprehended with subsection (5) of this rule which supplies Skilled Nursing Facility Coverage must clearly and conspicuously state in the Outline of Coverage that the nursing home coverage provided will not cover all nursing home expenses, only Medicare eligible expenses in a Skilled Nursing Facility approved by Medicare. Unless the policy explicitly provides otherwise, the Outline of Coverage must also state clearly and conspicuously that neither Medicare nor the policy will pay for "custodial care" or rest home care.

(b) Any policy which has not been approved by the commissioner as a Medicare supplement policy and which provides coverage for confinement or care in a nursing home must apply such coverage to any nursing facility and may not exclude coverage because that nursing facility is not Medicare - certified. Such nursing facility policies shall bear the following Caption: The provisions of this policy do not relate in any way to Medicare. This policy will not cover custodial care or rest home care. For more information, consult the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy.

(c) The Caption shall be placed on the front of each Outline of Coverage and on a separate half-sheet attached to the front of the policy. The Caption shall be conspicuously placed and printed in 18-point bold capital letters.

(8) HOSPITAL CONFINEMENT INDEMNITY COVERAGE. (a) Any hospital confinement indemnity coverage sold to a Medicare eligible person shall bear the following Caption: Attention Policyholder: This policy is *not* designed to fill the "gaps" of Medicare. It will compensate you only for a fixed dollar amount for a limited number of days you are hospital confined. For more information, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy.

(b) The Caption shall be placed on the front of each outline of coverage and on a separate half-sheet attached to the front of the policy. The Caption shall be conspicuously placed and printed in 18-point bold capital letters.

(9) SPECIFIED DISEASE COVERAGE. (a) No policy providing benefits for specified diseases, or treatments unique to specified diseases or additional benefits for such specified diseases or treatments shall be sold to a Medicare eligible person unless it bears the following Designation: SPECIFIED OR RARE DISEASE LIMITED POLICY, followed by this Caption: Attention Policyholder: This policy is designed to cover only narrowly-defined illnesses or threats to your health which are unusual compared to the health care problems of the general public. This policy should not be purchased as a substitute for broad-based health protection which could pay you for hospital and medical expenses incurred due to any of a variety of disorders. For more information, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy.

(b) The Caption shall be placed on the front of each outline of coverage and on a separate half-sheet attached to the front of the policy. The Caption shall be printed in 18-point bold capital letters.

(10) "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" PAMPHLET. Every prospective Medicare eligible purchaser of any policy subject to this rule must receive a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time the prospect is provided an application. This pamphlet prepared by the Office of the Commissioner of Insurance provides information on Medicare and advice to senior citizens on the purchase of Medicare supplement insurance and other health insurance. Insurers may obtain copies of this pamphlet from the Commissioner at cost or may reproduce this pamphlet themselves. This pamphlet shall be periodically revised to reflect changes in Medicare and any other appropriate changes. Prior to the publication of the revised pamphlet, it shall be submitted to the Disability Subcommittee of the Forms and Classification Advisory Council and the Insurance Consumers Advisory Council for review. No insurer shall be responsible for providing applicants the revised pamphlet until 30 days after the insurer has received notice that the revised pamphlet is available at the commissioner's office.

(11) APPROVAL NOT A RECOMMENDATION. While the commissioner may authorize the use of a particular Designation on a policy in accordance with this rule, that authorization is not to be construed or

advertised as a recommendation of any particular policy by the commissioner or the state of Wisconsin.

(12) SEVERABILITY. If any provision of this rule or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications or the rule which can be given effect without the invalid provision or application, and to this end the parts of the rule are declared to be severable.

(13) EFFECTIVE DATE. This rule shall take effect 120 days after publication of this rule or November 1, 1977, whichever is later.

Note: Subsequent to the adoption of this rule but prior to its effective date the pamphlet required by subsection (10) shall be revised pursuant to the procedures of that subsection. The revised pamphlet shall include information on this rule and contain other appropriate changes.

History: Cr. Register, July, 1977, No. 259, eff. 11-29-77.