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(b) The statutes of this state specifically prohibit a nondomestic insurer to engage in such business elsewhere; or

(c) The commissioner orders it to cease doing such business upon finding that doing such business is not consistent with the interests of its insureds, creditors or the public in this state; or that it gives the insurer a substantial competitive advantage in relation to domestic insurers.

(3) INCIDENTAL BUSINESS. “Incidental business” includes:

(a) The business of preparing and selling abstracts of title and related documents, if done by an insurer authorized to transact title insurance;

(b) Business that could be done through auxiliary subsidiaries authorized under s. 611.26 (3), or, in the case of a nondomestic insurer, through corporations that would be so authorized if the insurer were domestic.

(4) ANNUITIES. For purposes of this section, “insurance” includes “annuities”.

610.23 Power to hold property in other than own name.

An insurer shall hold all investments and deposits of its funds in its own name except that:

(1) CUSTODIAL OR TRUST ARRANGEMENTS. Securities kept under a custodial agreement or trust arrangement with a bank or banking and trust company may be issued in the name of a nominee of the bank or banking and trust company; and

(2) BEARER SECURITIES. Any insurer may acquire and hold securities in bearer form.

610.24 Insurers as fundholders.

All assets shall be held, invested and disbursed for the use and benefit of the insurer and no policyholder, member or beneficiary may have or acquire individual rights in such assets or become entitled to any apportionment or the surrender of any part of such assets, except as provided in the contract. An insurer may create, maintain, invest, disburse and apply any special funds necessary to carry out any purpose permitted by the laws of this state and the articles and bylaws of the insurer.

610.40 Continued effect of transitional provisions.

Sections 610.41 to 610.53, 1981 stats., continue to apply to insurers affected by those sections before April 27, 1984.

610.50 Vital records.

An insurer or an employee, agent or attorney of an insurer is not subject to s. 69.24 (1) (a) for copying a certified copy of a vital record for the insurer’s own internal administrative use in connection with the payment of insurance claims or benefits if the copy is marked “FOR ADMINISTRATIVE USE” and is retained in the files of the insurer or attorney.
610.60 ELECTRONIC DELIVERY OF NOTICES AND DOCUMENTS.

1. The party affirmatively consented to that method of delivery and has not withdrawn the consent.

2. Before the party gave consent, the insurer provided the party with a statement of the hardware and software requirements for access to and retention of notices and documents delivered by electronic means.

3. The party consented electronically, or confirmed consent electronically, in a manner that reasonably demonstrates that the party is able to access information in the electronic form that the insurer will use for delivery of notices and documents by electronic means.

4. Before the party gave consent, the insurer provided the party with a clear and conspicuous statement informing the party of all of the following:
   a. The right or option of the party to have notices and documents provided or made available in paper or another non-electronic form instead.
   b. The right of the party to withdraw consent to have notices and documents delivered by electronic means and any fees, conditions, or consequences that are imposed if consent is withdrawn.
   c. That the party’s consent applies to any notices or documents that may be delivered by electronic means during the course of the relationship between the party and the insurer.
   d. After consent for delivery by electronic means is given, the means, if any, by which a party may obtain a paper copy of a notice or document that has been delivered by electronic means and the fee, if any, for the paper copy.

610.60 ELECTRONIC DELIVERY OF NOTICES AND DOCUMENTS.

1. Definitions. In this section:

   a. “Applicable law” means applicable statutory law and rules and regulations having the force of law.

   b. “Deliver by electronic means” includes any of the following:
      1. Delivery to an electronic mail address at which a party has consented to receive notices or documents.
      2. Posting on an electronic network or site that is accessible via the Internet by using a mobile application, computer, mobile device, tablet, or any other electronic device and sending separate notice of the posting to a party, directed to the electronic mail address at which the party has consented to receive notice of the posting.
      3. A withdrawal of consent by a party does not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent becomes effective.

2. Electronic delivery permitted. Equivalent to other methods. (a) Subject to par. (c), subs. (3) and (5) (b), and s. 137.12 (2r) (c), notice to a party, and any other document that is required under applicable law in an insurance transaction that serves as evidence of insurance coverage, may be stored, presented, and delivered by electronic means, as long as the notice or other document meets the requirements of subch. II of ch. 137.

(b) Delivery of a notice or document in accordance with this section shall be considered equivalent to any delivery method required under applicable law, including delivery by 1st class mail; 1st class mail, postage prepaid; certified mail; or registered mail.

3. Conditions precedent for electronic delivery. (a) Unless sub. (5) (b) applies, an insurer may deliver notices and documents to a party by electronic means under this section if all of the following are satisfied:
   1. The party affirmatively consented to that method of delivery and has not withdrawn the consent.
   2. Before the party gave consent, the insurer provided the party with a statement of the hardware and software requirements for access to and retention of notices and documents delivered by electronic means.
   3. The party consented electronically, or confirmed consent electronically, in a manner that reasonably demonstrates that the party is able to access information in the electronic form that the insurer will use for delivery of notices and documents by electronic means.
   4. Before the party gave consent, the insurer provided the party with a clear and conspicuous statement informing the party of all of the following:
      a. The right or option of the party to have notices and documents provided or made available in paper or another non-electronic form instead.
      b. The right of the party to withdraw consent to have notices and documents delivered by electronic means and any fees, conditions, or consequences that are imposed if consent is withdrawn.
      c. That the party’s consent applies to any notices or documents that may be delivered by electronic means during the course of the relationship between the party and the insurer.
      d. After consent for delivery by electronic means is given, the means, if any, by which a party may obtain a paper copy of a notice or document that has been delivered by electronic means and the fee, if any, for the paper copy.
610.70 Disclosure of personal medical information.

(1) Definitions. In this section:

(a) “Health care provider” means any person licensed, registered, permitted or certified by the department of health services or the department of safety and professional services to provide health care services, items or supplies in this state.

(b) “Individual” means a natural person who is a resident of this state. For purposes of this paragraph, a person is a state resident if he or her last-known mailing address, according to the records of an insurer or insurance support organization, was in this state.

(c) “Insurance support organization” means any person that regularly engages in assembling or collecting personal medical information about natural persons for the primary purpose of providing the personal medical information to insurers for insurance transactions, including the collection of personal medical information from insurers and other insurance support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

2. Notwithstanding subd. 1., “insurance support organization” does not include insurance agents, government institutions, insurers or health care providers.

(d) “Insurance transaction” means any of the following involving insurance that is primarily for personal, family or household needs:

1. The determination of an individual’s eligibility for an insurance coverage, benefit or payment.

2. The servicing of an insurance application, policy, contract or certificate.

(e) “Medical care institution” means a facility, as defined in s. 647.01 (4), or any hospital, nursing home, community-based residential facility, county home, county infirmary, county hospital, county mental health center, adult family home, assisted living facility, rural medical center, hospice or other place licensed, certified or approved by the department of health services under s. 49.70, 49.71, 49.72, 50.02, 50.03, 50.032, 50.033, 50.034, 50.35, 50.52, 50.90, 51.04, 51.08, or 51.09 or a facility under s. 45.50, 51.05, 51.06, or 252.10 or under ch. 233, or licensed or certified by a county department under s. 50.032 or 50.033.

(f) 1. “Personal medical information” means information concerning an individual that satisfies all of the following:

a. Relates to the individual’s physical or mental health, medical history or medical treatment.

b. Is obtained from a health care provider, a medical care institution, the individual or the individual’s spouse, parent or legal guardian.

2. “Personal medical information” does not include information that is obtained from the public records of a governmental authority and that is maintained by an insurer or its representatives for the purpose of insuring title to real property located in this state.

(2) Disclosure authorization. (a) Any form that is used in connection with an insurance transaction and that authorizes the disclosure of personal medical information about an individual to an insurer shall comply with all of the following:

1. All instructions and other information contained in the form are presented in plain language.

2. The form is dated.

3. The form specifies the types of persons that are authorized to disclose information about the individual.

4. The form specifies the nature of the information that is authorized to be disclosed.

5. The form names the insurer, and identifies by generic reference representatives of the insurer, to whom the information is authorized to be disclosed.

6. The form specifies the purposes for which the information is being obtained.

7. Subject to par. (b), the form specifies the length of time for which the authorization remains valid.

8. The form advises that the individual, or an authorized representative of the individual, is entitled to receive a copy of the completed authorization form.

(b) 1. For an authorization under this subsection that will be used for the purpose of obtaining information in connection with an insurance policy application, an insurance policy reinstatement or a request for a change in policy benefits, the length of time spec-
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1. In plain language.

2. For an authorization under this subsection that will be used for the purpose of obtaining information in connection with a claim for benefits under an insurance policy, the length of time specified in par. (a) 7. may not exceed the policy term or the pendency of a claim for benefits under the policy, whichever is longer.

3. Access to recorded personal medical information.

(a) If, after proper identification, an individual or an authorized representative of an individual submits a written request to an insurer for access to recorded personal medical information that concerns the individual and that is in the insurer’s possession, within 30 business days after receiving the request the insurer shall do all of the following:

1. Inform the individual or authorized representative of the nature and substance of the recorded personal medical information in writing, by telephone or by any other means of communication at the discretion of the insurer.

2. At the option of the individual or authorized representative, permit the individual or authorized representative to inspect and copy the recorded personal medical information, in person and during the insurer’s normal business hours, or provide by mail to the individual or authorized representative a copy of the recorded personal medical information. If the recorded personal medical information is in coded form, the insurer shall provide to the individual or authorized representative an accurate written translation in plain language.

3. Disclose to the individual or authorized representative the identities, if recorded, of any persons to whom the insurer has disclosed, permitted or certified to provide health care services with respect to the condition to which the information relates. If the insurer chooses to provide the information to the designated health care provider under this paragraph, the insurer shall notify the individual or authorized representative, at the time of disclosure, that the information has been provided to the health care provider.

(b) Notwithstanding par. (a), an insurer may, in the insurer’s discretion, provide a copy of any recorded personal medical information requested by an individual or authorized representative under par. (a) to a health care provider who is designated by the individual or authorized representative or a medical care institution. The provider or medical care institution shall disclose to the individual or authorized representative the names of any insurance agents, insurance support organizations or other entities to whom such information is normally disclosed.

4. Provide to the individual or authorized representative a summary of the procedures by which the individual or authorized representative may request the correction, amendment or deletion of any recorded personal medical information in the possession of the insurer.

(b) Notwithstanding par. (a), an insurer may, in the insurer’s discretion, provide a copy of any recorded personal medical information requested by an individual or authorized representative under par. (a) to a health care provider who is designated by the individual or authorized representative or a medical care institution. The provider or medical care institution shall disclose to the individual or authorized representative the names of any insurance agents, insurance support organizations or other entities to whom such information is normally disclosed.

4. Provide to the individual or authorized representative a summary of the procedures by which the individual or authorized representative may request the correction, amendment or deletion of any recorded personal medical information in the possession of the insurer.

(c) An insurer is required to comply with par. (a) or (b) only if the individual or authorized representative provides a reasonable description of the information that is the subject of the request and if the information is reasonably easy to locate and retrieve by the insurer.

(d) If an insurer receives personal medical information from a health care provider or a medical care institution with instructions restricting disclosure of the information under s. 51.30 (4) (d) 1. to the individual to whom the information relates, the insurer may not disclose the personal medical information to the individual under this subsection, but shall disclose to the individual the identity of the health care provider or a medical care institution that provided the information.

(e) Any copy of recorded personal medical information provided under par. (a) or (b) shall include the identity of the source of the information if the source is a health care provider or a medical care institution.

(f) An insurer may charge the individual a reasonable fee to cover the costs incurred in providing a copy of recorded personal medical information under par. (a) or (b).

(g) The requirements for an insurer under this subsection may be satisfied by another insurer, an insurance agent, an insurance support organization or any other entity authorized by the insurer to act on its behalf.

(h) The requirements under this subsection do not apply to information concerning an individual that relates to, and that is collected in connection with or in reasonable anticipation of, a claim or civil or criminal proceeding involving the individual.

4. Correction, amendment or deletion of recorded personal medical information.

(a) Within 30 business days after receiving a written request from an individual to correct, amend or delete any recorded personal medical information that is in the insurer’s possession, an insurer shall do either of the following:

1. Comply with the request.

2. Notify the individual of all of the following:

   a. That the insurer refuses to comply with the request.

   b. The reasons for the refusal.

   c. That the individual has a right to file a statement as provided in par. (c).

(b) An insurer that complies with a request under par. (a) shall notify the individual of that compliance in writing and furnish the correction, amendment or fact of deletion to all of the following:

1. Any person who may have received, within the preceding 2 years, the recorded personal medical information concerning the individual and who is specifically designated by the individual.

2. Any insurance support organization for which insurers are the primary source of personal medical information and to which the insurer, within the preceding 7 years, has systematically provided recorded personal medical information. This subdivision does not apply to an insurance support organization that does not maintain recorded personal medical information concerning the individual.

3. Any insurance support organization that furnished to the insurer the personal medical information that has been corrected, amended or deleted.

(c) If an insurer refuses to comply with a request under par. (a) 1. , the individual making the request may file with the insurer, an insurance agent or an insurance support organization any of the following:

1. A concise statement setting forth the information that the individual believes to be correct, relevant or fair.

2. A concise statement setting forth the reasons why the individual disagrees with the insurer’s refusal to correct, amend or delete the recorded personal medical information.

(d) If the individual files a statement under par. (c), the insurer shall do all of the following:

1. File any statement filed by the individual under par. (c) with the recorded personal medical information that is the subject of the request under par. (a) in such a manner that any person reviewing the recorded personal medical information will be aware of and have access to the statement.

2. In any subsequent disclosure by the insurer of the recorded personal medical information, clearly identify any matter in dispute and provide any statement filed by the individual under par. (c) that relates to the recorded personal medical information along with the information.

3. Furnish any statement filed by the individual under par. (c) to any person to whom the insurer would have been required to furnish a correction, amendment or fact of deletion under par. (b).

(e) The requirements under this subsection do not apply to information concerning an individual that relates to, and that is collected in connection with or in reasonable anticipation of, a claim or civil or criminal proceeding involving the individual.
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610.80 Corporate governance annual disclosure.

(1) Definitions. In this section:

(a) “Insurance holding company system” has the meaning given in s. 622.03 (2).

(b) “Insurer” has the meaning given in s. 622.03 (3).

(c) “Lead state” has the meaning given in s. 622.03 (4).

(2) Disclosure requirement. (a) An insurer or insurance holding company system of which an insurer is a member shall, annually no later than June 1, submit to the commissioner a corporate governance annual disclosure that contains the information described in sub. (3). If the insurer is a member of an insurance holding company system, the insurance holding company system shall submit the disclosure to the commissioner of the lead state in accordance with the laws of the lead state. Upon the commissioner’s request, the insurer shall provide a copy of the disclosure when this state is not the lead state.

(b) The commissioner may request additional information from an insurer or insurance holding company system that the commissioner determines is necessary for the commissioner to understand an insurer’s or insurer member of an insurance holding company system’s corporate governance policies and the reporting or information system or controls implementing the policies.

(c) With respect to an insurer member of an insurance holding company system, if the commissioner wishes to review the disclosure under par. (a) or make a request for additional information about the disclosure under par. (a), the commissioner shall request the disclosure or additional information through the lead state before seeking the information from the insurer member of the insurance holding company system.

(d) The insurer or insurance holding company system has discretion over responses to inquiries regarding the disclosure under this section, provided that the disclosure is consistent with rules established by the commissioner regarding the disclosure and contains the material information necessary to permit the commissioner to gain an understanding of the insurer’s or insurer member of an insurance holding company system’s corporate governance structure, policies, and practices.

(3) Contents of disclosure. The disclosure under sub. (2) (a) shall include all of the following:

(a) The signature of the chief executive officer or corporate secretary of the insurer or insurance holding company system attesting that, to the best of that individual’s knowledge, the insurer has implemented the corporate governance practices described in the disclosure and that a copy of the disclosure was provided to the insurer’s board of directors or an appropriate committee of the insurer’s board of directors.

(b) An explanation of the level of corporate governance at which the disclosure provides its reporting, the criteria used to determine the level of reporting, and, if applicable, any change in the level of reporting from the previous disclosure. The insurer or insurance holding company system may provide information regarding corporate governance at the ultimate controlling parent, intermediate holding company, or individual legal entity level, depending upon how the insurer or insurance holding company system has structured its corporate governance. In determining at
which level of reporting an insurer or insurance holding company system will make its disclosure, the insurer or insurance holding company system shall consider at which level the insurer or insurance holding company system does each of the following:

1. Determines risk appetite.
2. Collectively oversees earnings, capital, liquidity, operations, and reputation.
3. Coordinates and exercises supervision over earnings, capital, liquidity, operations, and reputation.

(4) CONFIDENTIALITY. (a) All of the following apply to documents, materials, and other information in the possession or control of the commissioner that are obtained by, created by, or disclosed to the commissioner or any other person under this section:

1. The documents, materials, and other information are considered proprietary and contain trade secrets.
2. The documents, materials, and other information are confidential and privileged.
3. The documents, materials, and other information are not open to inspection or copying under s. 19.35 (1).
4. The documents, materials, and other information are not subject to subpoena or discovery and are not admissible as evidence in a civil action.
5. The commissioner may use the documents, materials, and other information in the furtherance of any regulatory or legal action brought as a part of the commissioner’s official duties.
6. The commissioner may not make the documents, materials, or other information public without first obtaining written consent of the insurer.

(b) Neither the commissioner nor any person who received documents, materials, or other information related to the corporate governance annual disclosure required under this section may testify or be required to testify in any private civil action regarding documents, materials, or other information related to the corporate governance annual disclosure required under this section.

(c) Notwithstanding par. (a), the commissioner may share, upon request, documents, materials, or other information related to the corporate governance annual disclosure required under this section with other state, federal, and international financial regulatory agencies if the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information and has verified that it has the legal authority to maintain confidentiality. The commissioner may receive documents, materials, or other information related to similar corporate governance disclosures from other state, federal, and international financial regulatory agencies and shall maintain as confidential or privileged any documents, materials, or other information that is treated as confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials, or other information. The sharing of documents under this paragraph does not constitute a delegation of regulatory authority and does not act as a waiver of privilege.

(d) Notwithstanding par. (a), the commissioner may share documents, materials, or other information related to the corporate governance annual disclosure required under this section with 3rd-party contractors and the National Association of Insurance Commissioners if the contractor or the National Association of Insurance Commissioners enters into an agreement with the commissioner that provides for all of the following:

1. Procedures and protocols for maintaining the confidentiality and security of documents, materials, and other information shared under this section.
2. Procedures for sharing by the National Association of Insurance Commissioners only with other state regulators in which the insurance group has domiciled insurers and who receive the information confidentially. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information related to the corporate governance annual disclosure required to be filed under this section and has verified in writing the legal authority to maintain confidentiality.
3. A provision specifying that the ownership of documents, materials, or other information shared under this section remains with the commissioner and the use of the information is at the direction of the commissioner.
4. A provision that prohibits the National Association of Insurance Commissioners or 3rd-party contractor from storing information shared under this paragraph in a permanent database after the underlying analysis is complete.
5. A provision requiring the National Association of Insurance Commissioners or 3rd-party contractor to provide prompt notice to the commissioner and to the insurer regarding any subpoena, request for disclosure, or request for production of information shared under this paragraph.
6. A requirement that the National Association of Insurance Commissioners or the 3rd-party contractor consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or the 3rd-party contractor may be required to disclose confidential information about the insurer shared under this paragraph.

(5) CONSULTANTS. The commissioner may retain, at the insurer’s or insurer member of an insurance holding company system’s expense, consultants that the commissioner determines are necessary to assist the commissioner in reviewing documents, materials, or other information submitted under this section.

(6) CONSTRUCTION. This section may not be read to prescribe or impose any standards or procedures with respect to corporate governance.

(7) RULE MAKING. The commissioner may promulgate any rules necessary to carry out the purposes of this section.

(8) INITIAL FILING DEADLINE. Notwithstanding the June 1 deadline under sub. (2) (a), an insurer, or the insurance holding company system of which the insurer is a member, that is required to file a corporate governance annual disclosure under this section shall file its first corporate governance annual disclosure no later than 60 days after the date the final rules implementing this section are promulgated.

History: 2017 a. 313.