CHAPTER 631

INSURANCE CONTRACTS GENERALLY

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Cross−reference: See definitions in ss. 600.03 and 628.02.

NOTE: Chapter 375, laws of 1975, which repealed and recreated this chapter, contains explanatory notes.

SUBCHAPTER I

GENERAL RULES

631.01 Application of statutes. (1) GENERAL. This chapter and ch. 632 apply to all insurance policies and group certificates delivered or issued for delivery in this state, on property ordinarily located in this state, on persons residing in this state when the policy or group certificate is issued, or on business operations in this state, except:

(a) As provided in ss. 600.01 and 618.42;

(b) On business operations in this state if the contract is negotiated outside this state and if the operations in this state are incidental or subordinate to operations outside this state, unless the contract is for a policy of insurance to cover a warranty, as defined in s. 100.205 (1) (g), in which case the provisions set forth in sub. (4m) apply; and

(c) As otherwise provided in the statutes.

(2) REINSURANCE. Sections 631.05, 631.15 (1), 631.41, 631.45 and 631.81 apply to contracts used in reinsurance; the commissioner may specify by rule that reinsurance contracts are subject to other provisions of this chapter and ch. 632 upon a finding that the interests of Wisconsin insureds, of ceding insurers domiciled in this state or of the public in this state so require.

(3) OCEAN MARINE INSURANCE. Sections 631.03 to 631.09, 631.15 (1) and (4), 631.20 (1), 631.27, 631.41 to 631.51, 631.64 to 631.81 and 631.85 apply to ocean marine insurance; the commissioner may specify by rule that ocean marine contracts are subject to other provisions of this chapter upon a finding that the interests of Wisconsin insureds or creditors or of the public in this state so require.

(4) ANNUITIES AND GROUP POLICIES FOR ELEEMOSYNARY INSTITUTIONS. This chapter and ch. 632 do not apply to annuities or group policies that are provided on a basis as uniform nationally as state statutes permit to educational, scientific research, religious or charitable institutions organized without profit to any person, for the benefit of employees of such institutions. The commissioner may by order subject such contracts issued by a particular insurer to this chapter or ch. 632 or any portion of those provisions upon a finding, after a hearing, that the interests of Wisconsin insureds or creditors or the public of this state so require.

(4m) RUSTPROOFING WARRANTIES INSURANCE. An insurer issuing a policy of insurance to cover a warranty, as defined in s. 100.205 (1) (g), shall comply with s. 632.18 and the policy shall be on a form approved by the commissioner under s. 631.20.

(5) OTHER EXCEPTIONS. The commissioner may by rule exempt any class of insurance contract or insurer from any or all of the provisions of this chapter and ch. 632 if the interests of Wisconsin insureds or creditors or of the public of this state do not require such regulation.

History: 1975 c. 375, 421; 1985 a. 29; 1987 a. 247; 1991 a. 250; 1995 a. 242; 1997 a. 27; 2007 a. 168; 2011 a. 224.

A stop−loss policy that provided that in case of catastrophic medical case, the employer would only be responsible for paying covered medical costs on an individual case up to the stop−loss amount with the insurer paying the costs above that amount, was not a contract of reinsurance exempt from this section. Edstrom Industries Inc. v. Companion Life, 516 F.3d 546 (2008).

631.02 Definition. "Interest of the insured," when used in an insurance policy, includes the interest of the named insured and of any other person with whom the named insured holds the insured property in joint tenancy or as marital property.

History: 1979 c. 102; 1983 a. 186; 2015 a. 196.

631.03 Insurance in mutuals. Any mutual under ch. 611 or 612 and any service corporation under ch. 613 may issue policies to any public or private corporation, board or association or to any unit of government, in any place in this state or elsewhere where it is authorized to do an insurance business. Any public or private corporation, board or association or unit of government in this state that is authorized to acquire insurance may make applications, enter into agreements for and hold policies in any mutual insurer or service corporation authorized under ch. 611, 612, 613 or 618.

History: 1975 c. 375.

631.05 Oral contracts of insurance and binders. No provision of chs. 600 to 646 and 655 may be interpreted to forbid an oral contract of insurance or issuance of a written binder. The insurer shall issue a policy as soon as reasonably possible after issuance of any binder or negotiation of an oral contract.

History: 1975 c. 375; 1979 c. 89; 1989 a. 187 s. 29.

631.07 Insurable interest and consent. (1) INSURABLE INTEREST. No insurer may knowingly issue a policy to a person without an insurable interest in the subject of the insurance.

(2) CONSENT IN LIFE AND DISABILITY INSURANCE. Except under sub. (3), no insurer may knowingly issue an individual life or disability insurance policy to a person other than the one whose life or health is at risk unless the latter has given written consent to the issuance of the policy. Consent may be expressed by knowingly signing the application for the insurance with knowledge of the nature of the document, or in any other reasonable way.

(3) CASES WHERE CONSENT IS UNNECESSARY OR MAY BE GIVEN BY ANOTHER. (a) *Consent unnecessary.* A life or disability insurance policy may be taken out without consent in any of the following cases:

1. A person may obtain insurance on a dependent who does not have legal capacity.

2. A creditor may at the expense of the creditor obtain life or disability insurance on the debtor in an amount reasonably related to the amount of the debt.

3. A person may obtain a life or disability insurance policy on members of the person's family living with or dependent on the person.

3m. A person may obtain a disability insurance policy on a child placed for adoption, as defined in s. 632.896 (1) (c), with the person.

4. A person may obtain a disability insurance policy on others that would merely indemnify against expenses the policyholder would be legally or morally obligated to pay.

(am) *Insurance for persons in international public service.* The commissioner may promulgate rules permitting issuance of insurance for a limited term on the life or health of a person serving outside the continental United States in the public service of the United States, provided the policyholder is closely related by blood, marriage or adoption to the person whose life or health is insured.

(b) *Consent given by another.* Consent may be given by another in the following cases:

1. A parent, a guardian of the person, or a person having legal custody as defined in s. 48.02 (12) may consent to the issuance of a policy on a dependent child.

2. A grandparent may consent to the issuance of life or disability insurance on a grandchild.

3. A court of general jurisdiction may give consent on ex parte application on the showing of any facts the court considers sufficient to justify such insurance.

(4) EFFECT OF LACK OF INSURABLE INTEREST OR CONSENT. No insurance policy is invalid merely because the policyholder lacks insurable interest or because consent has not been given, but a court with appropriate jurisdiction may order the proceeds to be paid to someone other than the person to whom the policy is designated to be payable, who is equitably entitled thereto, or may create a constructive trust in the proceeds or a part thereof, subject to terms and conditions of the policy other than those relating to insurable interest or consent.

History: 1975 c. 373, 375, 422; 1977 c. 354 s. 101; 1989 a. 336; 1999 a. 85; 1999 a. 162 s. 23; 2001 a. 38.

Cross−reference: See also s. Ins 2.45, Wis. adm. code.

The proceeds of a casualty insurance policy purchased by a land contract vendee that named the vendor as mortgagee were properly awarded to the vendor under sub. (4) when, following confirmation of a strict foreclosure judgment against the vendee, the insured premises were destroyed by fire. Disrud v. Arnold, 167 Wis. 2d 177, 482 N.W.2d 114 (Ct. App. 1992).

A stockholder may have an insurable interest in corporate property. Heyden v. Safeco Title Insurance Co. 175 Wis. 2d 508, 498 N.W.2d 905 (Ct. App. 1993).

631.08 Mistakes in contracts. (1) GENERAL. Except as otherwise provided in chs. 600 to 646 and 655, general contract law applies to mistakes in insurance contracts.

(2) PERSON TO WHOM PROCEEDS PAYABLE IN PROPERTY INSURANCE. Mistake in designating the person to whom the insurance is payable in a policy of property insurance does not void the policy nor constitute a defense for the insurer unless the mistake was due to misrepresentation or concealment by the owner of the property or someone representing the owner in procuring the policy, or unless the company would not have issued or continued the policy if it had known the truth.

History: 1975 c. 375, 421; 1979 c. 89; 1989 a. 187 s. 29.

631.09 Knowledge and acts of agents. (1) IMPUTATION OF KNOWLEDGE. An insurer is deemed to know any fact material to the risk or which breaches a condition of the policy, if the agent who bound the insurer or issued the policy or transmitted the application to the insurer knew it at the time the agent acted, or if thereafter any of the insurer's agents with whom the policyholder is then dealing as agent of the insurer learns it in the course of the agent's dealing with the policyholder, and knows that it pertains to a policy written by the insurer.

(2) ACTS OF AGENT. A failure by any policyholder or insured to perform an act required to perfect his or her rights under the policy, or failure to perform the act in the time and manner prescribed, does not affect the insurer's obligations under the policy if the failure was caused by an act, statement or representation or omission to perform a duty by an agent of the insurer who has apparent authority, whether or not the agent was within the actual scope of the agent's authority.

(3) EFFECT OF NOTICE TO AGENT. Notice given by or on behalf of the policyholder or insured to any authorized agent of the insurer with particulars sufficient to identify the policy is notice to the insurer.

(4) COLLUSION. Subsections (1) and (2) do not apply if the agent and the policyholder or insured acted in collusion to deceive or defraud the insurer, or if the policyholder or insured knew the agent was acting beyond the scope of the agent's authority.

(5) GROUP POLICYHOLDER NOT AGENT. No person is an agent of an insurer merely because the person is a policyholder of a group insurance policy.

(6) LIABILITY UNDER COMMON LAW. This section does not diminish any liability of the insurer that would exist under common law.

History: 1975 c. 375, 421.

Absent proof that an agent knew, or should have known, of financial problems of a reinsurer from whom the agent procured insurance, the agent is not liable when the reinsurer later becomes insolvent. Master Plumbers Mut. Liab. v. Cormany & Bird, 79 Wis. 2d 308, 255 N.W.2d 533 (1977).

When an insured elected to have open heart surgery after an agent indicated that the insurer would probably pay the bills, that action was sufficient reliance to estop the insurer from denying coverage. Nolden v. Mutual Benefit Life Insurance Co. 80 Wis. 2d 353, 259 N.W.2d 75 (1977).

631.11 Representations, warranties and conditions. (1) EFFECT OF NEGOTIATIONS FOR CONTRACT. (a) *Statement or warranty.* No statement, representation or warranty made by a person other than the insurer or an agent of the insurer in the negotiation for an insurance contract affects the insurer's obligations under the policy unless it is stated in any of the following:

1. The policy.

2. A written application signed by the person, provided that a copy of the written application is made a part of the policy by attachment or endorsement.

3. A written communication provided by the insurer to the insured within 60 days after the effective date of the policy.

(b) *Misrepresentation or breach of affirmative warranty.* No misrepresentation, and no breach of an affirmative warranty, that is made by a person other than the insurer or an agent of the insurer in the negotiation for or procurement of an insurance contract constitutes grounds for rescission of, or affects the insurer's obligations under, the policy unless, if a misrepresentation, the person knew or should have known that the representation was false, and unless any of the following applies:

1. The insurer relies on the misrepresentation or affirmative warranty and the misrepresentation or affirmative warranty is either material or made with intent to deceive.

2. The fact misrepresented or falsely warranted contributes to the loss.

(3) EFFECT OF FAILURE OF CONDITION OR BREACH OF PROMISSORY WARRANTY. No failure of a condition prior to a loss and no breach of a promissory warranty constitutes grounds for rescission of, or affects an insurer's obligations under, an insurance policy unless it exists at the time of the loss and either increases the risk at the time of the loss or contributes to the loss. This subsection does not apply to failure to tender payment of premium.

(4) EFFECT OF INSURER'S KNOWLEDGE. (a) *Knowledge when policy issued.* No misrepresentation made by or on behalf of a policyholder and no breach of an affirmative warranty or failure of a condition constitutes grounds for rescission of, or affects an insurer's obligations under, an insurance policy if at the time the policy is issued the insurer has either constructive knowledge of the facts under s. 631.09 (1) or actual knowledge. If the application is in the handwriting of the applicant, the insurer does not have constructive knowledge under s. 631.09 (1) merely because of the agent's knowledge.

(b) *Knowledge acquired after policy issued.* If after issuance of an insurance policy an insurer acquires knowledge of sufficient facts to constitute grounds for rescission of the policy under this section or a general defense to all claims under the policy, the insurer may not rescind the policy and the defense is not available unless the insurer notifies the insured within 60 days after acquiring such knowledge of its intention to either rescind the policy or defend against a claim if one should arise, or within 120 days if the insurer determines that it is necessary to secure additional medical information.

(4m) LIFE AND DISABILITY CONTRACTS. (a) *Copy of application to be made available.* The policyholder under a life or disability insurance policy and any person whose life or health is insured under the policy may request in writing a copy of the application if he or she did not receive the policy or a copy of it, or if the policy has been reinstated or renewed without attachment of a copy of the original application. If the insurer does not deliver or mail a copy as requested within 15 working days after receipt of the request by the insurer or its agent or, in the case of a group policy certificate holder, does not inform such person within the same period how he or she may inspect the policy and application during normal business hours at a place reasonably convenient to the certificate holder, nothing in the application affects the insurer's obligations under the policy to the person making the request. A person whose life or health is insured under a group life or disability insurance policy has the same right to request a copy of any document specified in par. (b), including the certificate.

(b) *Statement or warranty.* No statement, representation or warranty made by or on behalf of a particular certificate holder under a group life or disability insurance policy affects the insurer's obligations under the certificate unless it is stated in the certificate, or in a written document signed by the certificate holder, a copy of which is supplied to the certificate holder or the beneficiary whose rights would be affected.

(5) FRATERNALS. This section applies to fraternals, as defined in s. 614.01 (1) (a).

(6) INCONTESTABILITY PROVISIONS. This section is subject to ss. 632.46 and 632.76.

History: 1975 c. 375, 421; 1977 c. 339 s. 44; Stats. 1977 s. 641.11; 1983 a. 189 s. 329 (25); 1995 a. 259.

If a question on a form calls for the applicant's judgment or opinion as a lay person, any ambiguity should be construed against the insurer. Nolden v. Mutual Benefit Life Ins. Co. 80 Wis. 2d 353, 259 N.W.2d 75 (1977).

An insured's contradictory statements constituted a breach of the contractual duties of notice and cooperation. Dietz v. Hardware Dealers Mut. Fire Ins. Co. 88 Wis. 2d 496, 276 N.W.2d 808 (1979).

Third parties may recover against an insurer even though the insured's fraudulent application voided the policy under s. 631.11. Rauch v. American Family Insurance Co. 115 Wis. 2d 257, 340 N.W.2d 478 (1983).

Sub. (2) [now sub. (1) (b)] applies a reliance test to misrepresentations made in the negotiation or application for insurance, and not to statements made in proof of loss forms. Tempelis v. Aetna Casualty & Surety Co. 164 Wis. 2d 17, 473 N.W.2d 549 (Ct. App. 1991).

In order to make a written application form a part of an insurance policy by endorsement, the insurer must specifically write across the application itself that it is an endorsement and part of the policy. Smith v. Dodgeville Mutual Insurance Co. 212 Wis. 2d 226, 568 N.W.2d 31 (Ct. App. 1997), 96−3352.

Sub. (3) only applies to conditions subsequent to a policy becoming effective, not conditions precedent. Conditions to the making of the contract, conditions precedent, cannot be implicated by the statute because the policy has not yet come into existence. Fox v. Catholic Knights Ins. Society, 2003 WI 87, 263 Wis. 2d 207, 665 N.W.2d 181, 01−1469.

This section does not supersede the known−loss doctrine. That doctrine may apply whether or not the requirements of subs. (1) (b) and (4) (b) are met. American Family Family Mutual Ins. Co. v. Bateman, 2006 WI App 251, 297 Wis. 2d 828, 726 N.W.2d 678, 05−2219.

Sub. (1) (b) establishes the elements necessary to entitle an insurance company to rescind an insurance contract. There must be an affirmative warranty or misrepresentation, which is a question of law. Whether the statement was false, and whether the person making the statement knew, or should have known, that the statement was false are questions of fact. The burden of proof on an insurer seeking to rescind an insurance contract is clear and convincing evidence as to each element of the statute. Pum v. Wisconsin Physicians Service Insurance Corporation, 2007 WI App 10, 298 Wis. 2d 497, 727 N.W.2d 346, 05−3049.

631.13 Incorporation by reference. No insurance contract may contain any agreement or incorporate any provision not fully set forth in the policy or in an application or other document attached to and made a part of the policy at the time of its delivery except that:

(1) RATES. Any policy may by reference incorporate rate schedules and classifications of risks and short−rate tables filed with the commissioner; and

(2) COMPLEX CONTRACTS. By rule or order or by approval of a form the commissioner may authorize for complex contracts incorporation by reference of provisions for administrative arrangements, premium schedules and payment procedures.

History: 1975 c. 375.

631.15 Contract rights under noncomplying policies. **(1)** ENFORCEMENT OF POLICY TERMS. Except as otherwise specifically provided by statute, a policy is enforceable against the insurer according to its terms, even if it exceeds the authority of the insurer.

(3m) ENFORCEMENT OF STATUTE AND RULE REQUIREMENTS. A policy that violates a statute or rule is enforceable against the insurer as if it conformed to the statute or rule.

(4) REFORMATION OF CONTRACT. Upon written request of the policyholder or an insured whose rights under the policy are continuing and not transitory, an insurer shall reform and reissue its written policy to comply with the requirements of the law existing at the date of issue or last renewal of the policy.

History: 1975 c. 375; 1987 a. 247.

When uninsured motorist coverage in the amount of $25,000 was contracted for, in violation of the requirement for $50,000 coverage under s. 632.32 (4m) (d), the higher level of coverage was read into the policy under sub. (3m), even though it was not reflected in the premium paid. Brunson v. Ward, 2001 WI 89, 245 Wis. 2d 163, 629 N.W.2d 140, 98−3002.

631.17 Written reason for coverage denial. **(1)** In this section, "disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(2) An insurer that denies coverage under an individual or group life or disability insurance policy or a certificate of group life or disability insurance shall advise the applicant or proposed insured in writing of the reasons for the denial.

History: 1999 a. 95.

SUBCHAPTER II

APPROVAL OF FORMS

631.20 Filing and approval of forms. **(1)** FILING. (a) No form subject to s. 631.01 (1), except as exempted under par. (c), sub. (1g), or s. 631.01 (2), (3), (4), or (5) or by rule under par. (b), may be used unless it has been filed with and approved by the commissioner and unless the insurer certifies that the form complies with chs. 600 to 655 and rules promulgated under chs. 600 to 655. It is deemed approved if it is not disapproved within 30 days after filing, or within a 30−day extension of that period

ordered by the commissioner prior to the expiration of the first 30 days.

(b) Subject to s. 655.24 (1), the commissioner may by rule exempt certain classes of policy forms from prior filing and approval.

(c) Subject to sub. (1m), a form first used and not already filed under par. (a) on or after August 1, 2008, is exempt from par. (a) except for any of the following:

1. A form subject to s. 655.24 (1).

2. A form for a worker's compensation policy.

3. A form for a Medicare replacement policy or a Medicare supplement policy.

4. A form for a long−term care insurance policy, including a form for a nursing home or home health care policy.

6. A form issued by an insurer ordered by the commissioner under s. 601.41 (4) to file forms under par. (a). The commissioner may require an insurer to file forms under par. (a) to secure compliance with the law, including if the commissioner determines that the insurer violated sub. (1m).

7. A form that includes an appraisal or arbitration provision not specifically authorized by rule. The entire form, including the appraisal or arbitration provision, is subject to par. (a).

8. A form that contains a clause subject to s. 631.21, but only as to the clause.

9. A form for a policy of insurance to cover a warranty, as defined in s. 100.205 (1) (g).

10. A warranty contract form.

11. A form required to be filed under par. (a) by a rule promulgated by the commissioner.

(1g) EXEMPT IF APPROVED BY COMMISSION. A form for a product, as defined in s. 601.58 (2) (k), that is approved by or self−certified to, and not disapproved by, the Interstate Insurance Product Regulation Commission is exempt from subs. (1) (a) and (1m) (a), unless otherwise provided by a rule promulgated by the commissioner under s. 601.58.

(1m) USE OF CERTAIN FORMS. (a) Except as exempted under sub. (1g) or s. 631.01 (2), (3), (4), or (5) or by a rule promulgated by the commissioner, an insurer may not, on or after August 1, 2008, use a form that is exempt from sub. (1) (a) under sub. (1) (c) unless the insurer does all of the following:

1. Files the form with the commissioner 30 days before its use.

2. Files the form in the manner and format, and with the attachments, prescribed by the commissioner.

3. Certifies as required under par. (b) that the form complies with chs. 600 to 655 and rules promulgated under chs. 600 to 655. The commissioner may require an insurer to include specific compliance certifications.

(b) An insurer shall provide the certification under par. (a) 3. in the form prescribed by the commissioner. The certification shall be executed by a person who is an officer of the insurer and who is responsible for the form that is the subject of the filing. No insurer may file, and no insurer's officer may execute, a false certification.

(2) GROUNDS FOR DISAPPROVAL. The commissioner may disapprove a form under sub. (1) (a) or (3) upon a finding:

(a) That it is inequitable, unfairly discriminatory, misleading, deceptive, obscure or encourages misrepresentation, including cases where the form:

1. Is misleading because its benefits are too restricted to achieve the purposes for which the policy is sold;

2. Contains provisions whose natural consequence is to obscure or lessen competition;

3. Is unnecessarily verbose or complex in language; or

4. Is misleading, deceptive or obscure because of such physical aspects as format, typography, style, color, material or organization;

(b) That it provides benefits or contains other provisions that endanger the solidity of the insurer;

(c) That in the case of the policy, though not of riders and endorsements, it fails to provide the exact name of the insurer and the full address of its home office; or

(d) That it violates a statute or a rule promulgated by the commissioner, or is otherwise contrary to law.

(e) That its use would violate s. 631.22.

(3) SUBSEQUENT DISAPPROVAL. Whenever the commissioner finds, after a hearing, that a form approved or deemed to be approved under sub. (1) (a), a form filed under sub. (1m), or a form subject to subsequent disapproval under s. 601.58 (14) should be disapproved under sub. (2), the commissioner may order that on or before a date not less than 30 nor more than 90 days after the order the use of the form shall be discontinued or appropriate changes shall be made.

(4) CONTENTS OF ORDER OF DISAPPROVAL. The commissioner's disapproval must be in writing and constitutes an order. It must state the reasons for disapproval sufficiently explicitly that the insurer is provided reasonable guidance in reformulating its proposals.

(5) EXPLICIT APPROVAL OF CERTAIN CLAUSES. General approval of a form under this section, or failure to disapprove, does not constitute approval of clauses specified in s. 631.21.

(6) FORM THAT VIOLATES STATUTE OR RULE. (a) The penalties under s. 601.64 (3) to (5) may not be imposed against an insurer for any of the following:

1. Using a form that does not comply with a statute or rule, including a rule or uniform standard adopted by the Interstate Insurance Product Regulation Commission, if the statute or rule was in effect on the date the form was approved or deemed to be approved under sub. (1) (a) or s. 601.58.

2. The use of a form solely based on a finding of the commissioner that the content of the form is misleading under s. 628.34 (1).

(b) An insurer's use of a form that does not comply with a statute or rule, including a rule or uniform standard adopted by the Interstate Insurance Product Regulation Commission, that takes effect after the date the form was approved or deemed to be approved under sub. (1) (a) or s. 601.58 is a violation of the statute or rule, and the penalties under s. 601.64 may be imposed against the insurer using the form.

(c) Except as provided in par. (a) 2., an insurer's use of a form filed under sub. (1m) that violates chs. 600 to 655 or rules promulgated under chs. 600 to 655 is a violation of the statute or rule, regardless of whether the form has been subsequently disapproved under sub. (3). The insurer is subject to the penalties and remedial orders provided under chs. 600 to 655, including ss. 601.41 (4) and 601.64.

(7) SURPLUS LINES INSURANCE. Except as provided in sub. (1) (c) 9. and s. 618.41 (6m), this section does not apply to a surplus lines insurance form issued under s. 618.41 before, on, or after April 20, 2012.

History: 1975 c. 375, 421; 1979 c. 218; 1987 a. 247; 1999 a. 9; 2005 a. 74; 2007 a. 168; 2011 a. 224; 2013 a. 20.

Cross−reference: See also ss. Ins 6.05, 6.07, and 6.76, Wis. adm. code.

631.21 Explicit approval required. (1) REQUIRED APPROVAL. Despite filing or general approval of a form under s. 631.20, the following clauses may not be used even if contained in the form unless the commissioner gives explicit approval to them:

(a) *Expeditious notice.* Clauses requiring more expeditious notice than 1st class mail, as provided in s. 631.81 (2).

(c) *Reinstatement fees.* A schedule of reinstatement fees under s. 632.74, if made a part of the policy. Such a schedule need not be included in the contract but may be given approval as a separate

document specifically made applicable to particular classes of policies.

(2) EFFECT OF FAILURE TO OBTAIN EXPLICIT APPROVAL. If an insurer fails to obtain explicit approval from the commissioner for the clauses under sub. (1), the clauses shall be null and void.

History: 1975 c. 375; 1985 a. 280; 2007 a. 168.

Cross−reference: See also ss. Ins 6.05 and 6.07, Wis. adm. code.

631.22 Consumer insurance policy readability. (1) In this section "consumer insurance policy" means a life, disability, property or casualty insurance policy, or a certificate or a substitute for a certificate for group life, disability, property or casualty insurance coverage, which is issued to a person for a personal, family or household purpose and a copy of which is customarily, in the insurance industry, delivered or is required by law, rule or agreement to be delivered to the person obtaining insurance coverage.

(2) An insurer may provide a consumer insurance policy which is delivered to a person obtaining insurance coverage and is not exempt under sub. (5) only if the consumer insurance policy is coherent, written in commonly understood language, legible, appropriately divided and captioned by its various sections and presented in a meaningful sequence. The commissioner shall promulgate rules establishing standards for the determination of compliance with this subsection.

(3) This section does not apply to specific language or format required by state or federal law, rule or regulation.

(4) This section applies only to consumer insurance policies delivered on or after the date which is 6 months after May 8, 1980 except the commissioner may provide by rule that this section will not apply to specific types of consumer insurance policies until a later date which is not later than the date which is 2 years after May 8, 1980 if the commissioner determines that delayed application is necessary to prevent an unreasonable burden upon insurers issuing those types of consumer insurance policies.

(5) The commissioner may by rule exempt a type of consumer insurance policy from the application of this section if the commissioner finds that type of consumer insurance policy is generally understood by persons to whom it is delivered or that those persons are otherwise adequately protected.

(6) A violation of this section does not void or render voidable any portion of an insurance policy and is not a defense to an action under the insurance policy.

History: 1979 c. 218.

631.23 Authorized clauses for insurance forms. (1) PROMULGATION OF CLAUSES. The commissioner may not promulgate mandatory uniform clauses that preclude an insurer from filing its own forms under s. 631.20; the commissioner may only disapprove such forms on the basis of the criteria stated in that section. Subject thereto, the commissioner may promulgate authorized clauses by rule upon a finding that:

(a) Price or coverage competition is ineffective because diversity in language or content makes comparison difficult;

(b) Provision of language, content or form of specific clauses is necessary to provide certainty of meaning of those clauses;

(c) Regulation of contract forms would be more effective or litigation would be substantially reduced if there were increased standardization of certain clauses; or

(d) Reasonable minimum standards of insurance protection are needed for policies to serve a useful purpose.

(2) DEGREE OF SPECIFICITY. Any rule creating an authorized clause may prescribe that to be treated as an authorized clause there must be verbatim or substantial adherence to prescribed language, that certain standards or criteria must be met, or that certain drafting principles must be followed. The rules may also permit liberalization of prescribed language. If the proposed rule prescribed verbatim adherence, the commissioner shall make a finding that substantial adherence to the prescribed language is not sufficient and that liberalization of prescribed language will frustrate the purposes of the prescription. If an insurer uses authorized clauses as part of filed forms the commissioner may only disapprove those clauses under s. 631.20 upon a finding that improper combination of clauses makes them violate the criteria of s. 631.20.

History: 1975 c. 375, 421; 1979 c. 221; 2007 a. 168.

Cross−reference: See also s. Ins 6.76, Wis. adm. code.

631.24 Credit life and disability insurance. Section 631.20 does not apply to credit life and disability insurance forms which are subject to approval under s. 424.209.

History: 1979 c. 102.

631.27 Rules of law as provisions of contracts. By rule, the commissioner may require an insurer to insert in a policy any rule of law stated in chs. 600 to 646 and 655 that is applicable to the contents or interpretation of an insurance contract.

History: 1975 c. 375; 1979 c. 89; 1989 a. 187 s. 29.

631.28 Notice of right to file complaint. (1) REQUIREMENT TO PROVIDE NOTICE. Every insurer shall provide notice to its policyholders and its insureds of the right to file a complaint with the office in the manner prescribed by rule under sub. (2).

(2) CONTENTS BY RULE. The commissioner shall promulgate rules specifying the contents of a notice that insurers must disseminate under sub. (1), and when and in what manner the notice must be provided. The rules shall describe how a policyholder, insured or other person may make a complaint with the office about an insurer, an intermediary or other insurance matter. The rules may also specify the form, including the type size, in which insurers must present the notice.

History: 1991 a. 154.

Cross−reference: See also s. Ins 6.85, Wis. adm. code.

SUBCHAPTER III

SPECIFIC CLAUSES IN CONTRACTS

631.31 Clauses required to be on first page. (1) LIST OF CLAUSES. The following clauses of insurance policies shall appear on the first page of the policy:

(a) *Corporate name.* The name of the insurer as required by s. 631.64;

(b) *Several liability.* Information that 2 or more insurers undertake only several liability, as required by s. 631.41;

(c) *Assessability.* That the policy is assessable as required by s. 631.65;

(d) *Variable benefits.* A statement that benefits are variable, as required by s. 632.45 (1); and

(e) *Right to return policy.* The right to return a disability insurance policy under s. 632.73, except that this clause may be conspicuously attached to the first page rather than printed on it.

(2) MANNER OF DISPLAY. Clauses listed in sub. (1) shall be displayed conspicuously and separately from any other clauses.

History: 1975 c. 375; 1981 c. 218.

631.36 Termination of insurance contracts by insurers. (1) SCOPE OF APPLICATION. (a) *General.* Except as otherwise provided in this section or in other statutes or by rule under par. (c), this section applies to all contracts of insurance based on forms that are subject to filing under s. 601.58 or 631.20.

(b) *Contracts more favorable to policyholder.* The contract may provide terms more favorable to policyholders than are required by this section.

(c) *Exemption by rule.* The commissioner may by rule totally or partially exempt from this section classes or parts of classes of insurance contracts if the policyholders do not need protection against arbitrary or unannounced termination.

(d) *Other rights.* The rights provided by this section are in addition to and do not prejudice any other rights the policyholder may have at common law or under other statutes.

(e) *Rescission or reformation.* This section does not apply to the rescission or reformation of any insurance contract.

(2) MIDTERM CANCELLATION. (a) *Permissible grounds.* Except as provided by par. (c) and sub. (3) and s. 655.24 (2) (b), no insurance policy may be canceled by the insurer prior to the expiration of the agreed term except for failure to pay a premium when due or on grounds stated in the policy, which must be comprehended within one of the following classes:

1. Material misrepresentation;

2. Substantial change in the risk assumed, except to the extent that the insurer should reasonably have foreseen the change or contemplated the risk in writing the contract;

3. Substantial breaches of contractual duties, conditions or warranties; or

4. Attainment of the age specified as the terminal age for coverage, in which case the insurer may cancel by notice under par. (b) accompanied by a tender of a proportional return of premium.

(b) *Notice.* No cancellation under par. (a) is effective until at least 10 days after the 1st class mailing or delivery of a written notice to the policyholder.

(c) *New policies.* Paragraphs (a) and (b) do not apply to any insurance policy that has not been previously renewed if the policy has been in effect less than 60 days at the time the notice of cancellation is mailed or delivered. No cancellation under this paragraph is effective until at least 10 days after the 1st class mailing or delivery of a written notice to the policyholder. Subsections (6) and (7) do not apply to such a policy.

(3) ANNIVERSARY CANCELLATION OR ALTERATION. A policy may be issued for a term longer than one year or for an indefinite term with a clause providing for cancellation by the insurer in the manner provided in sub. (4) (a) for nonrenewals, except the notice must be given at least 60 days prior to any anniversary date and an insurer may not cancel a policy solely because of the termination of an insurance marketing intermediary's contract with the insurer unless the insurer complies with sub. (4m). The clause may also provide for alteration of the terms or premium by the insurer as provided in sub. (5) (c), except the clause must then permit cancellation by the policyholders as provided in sub. (5) (c).

(4) NONRENEWAL. (a) *Notice required.* Subject to subs. (2) and (3), a policyholder has a right to have the policy renewed, on the terms then being applied by the insurer to similar risks, for an additional period of time equivalent to the expiring term if the agreed term is one year or less, or for one year if the agreed term is longer than one year, unless at least 60 days prior to the date of expiration provided in the policy a notice of intention not to renew the policy beyond the agreed expiration date is mailed or delivered to the policyholder, or with respect to failure timely to pay a renewal premium a notice is given, not more than 75 days nor less than 10 days prior to the due date of the premium, which states clearly the effect of nonpayment of premium by the due date.

(am) *Prohibited nonrenewals.* Notwithstanding par. (a) an insurer may not refuse to renew a policy solely because of the termination of an insurance marketing intermediary's contract with the insurer unless the insurer complies with sub. (4m).

(b) *Exceptions.* This subsection does not apply if the policyholder has insured elsewhere, has accepted replacement coverage or has requested or agreed to nonrenewal, or if the policy is expressly designated as nonrenewable.

(4m) POLICY CANCELLATION. An insurer may refuse to renew or may cancel a policy under sub. (3) or (4) solely because of the termination of an insurance marketing intermediary's contract with the insurer only if the notice of nonrenewal or cancellation contains an offer to continue or renew the policy with the insurer if the insurer receives a written request from the policyholder prior to the cancellation or renewal date. The insurer shall continue or renew the policy if a timely request is received unless the policyholder does not meet normal underwriting criteria.

(5) RENEWAL WITH ALTERED TERMS. (a) *General.* Subject to pars. (b) and (d), if the insurer offers or purports to renew the policy but on less favorable terms or at higher premiums, the new terms or premiums take effect on the renewal date if the insurer sent by 1st class mail or delivered to the policyholder notice of the new terms or premiums at least 60 days prior to the renewal date. If the insurer notifies the policyholder within 60 days prior to the renewal date, the new terms or premiums do not take effect until 60 days after the notice is mailed or delivered, in which case the policyholder may elect to cancel the renewal policy at any time during the 60−day period. The notice shall include a statement of the policyholder's right to cancel. If the policyholder elects to cancel the renewal policy during the 60−day period, return premiums or additional premium charges shall be calculated proportionately on the basis of the old premiums. If the insurer does not notify the policyholder of the new premiums or terms as required by this subsection prior to the renewal date, the insurer shall continue the policy for an additional period of time equivalent to the expiring term and at the same premiums and terms of the expiring policy, except as permitted under sub. (2) or (3).

(b) *Exception.* Paragraph (a) does not apply if the only change that is adverse to the policyholder is a premium increase and if either of the following applies to the premium increase:

1. The premium increase is less than 25 percent and is generally applicable to the class of business to which the policy belongs.

2. The premium increase results from a change based on action by the insured that alters the nature or extent of the risk insured against, including but not limited to a change in the classification or the units of exposure or increased policy coverage.

(c) *Anniversary alteration.* Subject to par. (d), an insurer may alter the terms or premium of a policy issued for a term longer than one year or for an indefinite term on the anniversary date only if notice of less favorable terms or premiums is sent by 1st class mail or delivered to the policyholder at least 60 days prior to the anniversary date. If the insurer notifies the policyholder within 60 days prior to the anniversary date, the new terms or premiums do not take effect until 60 days after the notice is mailed or delivered, in which case the policyholder may elect to cancel the policy at any time during the 60−day period. The notice shall include a statement of the policyholder's right to cancel. If the policyholder elects to cancel the policy during the 60−day period, return premiums or additional premium charges shall be calculated proportionately on the basis of the old premiums. If the insurer does not notify the policyholder of the new premiums or terms as required by this subsection prior to the anniversary date, the insurer shall continue the policy until the next anniversary date or the renewal date, whichever is earlier, at the same premiums and terms as for the previous period, except as permitted under sub. (2) or (3).

(d) *Estimate.* An insurer may give notice under par. (a) or (c) of a new premium by stating the actual amount or percentage increase to be charged. If the insurer cannot reasonably determine the actual amount or percentage increase 60 days prior to the renewal or anniversary date, the notice shall include a good faith estimate of the increase based on information that the insurer can reasonably obtain. If an estimate is stated, the insurer shall renew or continue the policy at a premium that does not exceed the increase stated in the notice except as permitted under sub. (5) (b).

(6) INFORMATION ABOUT GROUNDS. A notice of cancellation or nonrenewal under sub. (2) (b) or (4) shall state with reasonable precision the facts on which the insurer's decision is based. No such notice is effective unless it so states the facts.

(7) CANCELLATION OR NONRENEWAL NOTICE. (a) Except as provided in par. (b), notice of cancellation or nonrenewal required under sub. (2) (b) or (4) is not effective unless the notice contains adequate instructions to the policyholder for applying for insurance through a risk−sharing plan under ch. 619, if a risk−sharing plan exists under ch. 619 for the kind of coverage being canceled or nonrenewed.

(b) Paragraph (a) does not apply to a notice of cancellation or nonrenewal issued by the mandatory health care liability risk−sharing plan established under s. 619.04.

(8) CANCELLATION FOR NONPAYMENT OF PREMIUM. Subsections (6) and (7) do not apply if the ground for cancellation or nonrenewal is nonpayment of the premium and if the notice so states.

(9) IMMUNITY. There is no liability on the part of and no cause of action of any nature arises against any insurer, its authorized representatives, its agents, its employees, or any firm, person or corporation furnishing to the insurer information relating to the reasons for cancellation or nonrenewal, for any statement made by them in complying or enabling the insurer to comply with this section, or for the provision of information pertaining thereto.

History: 1975 c. 375, 421; 1977 c. 444 s. 11; 1979 c. 102; 1979 c. 110 s. 60 (11); 1981 c. 83; 1985 a. 335; 1989 a. 187, 332, 359; 1991 a. 315; 1995 a. 259; 1997 a. 27; 1999 a. 9; 2007 a. 168; 2013 a. 20.

Cross−reference: See also s. Ins 6.77, Wis. adm. code.

Sub. (2) (c) applies to cancellation of a binder. Terry v. Mongin Insurance Agency, 105 Wis. 2d 575, 314 N.W.2d 349 (1982).

A policy did not lapse as the result of the insured's failure to pay a renewal premium before the policy's expiration date when the insurer failed to notify the insured of the nonrenewal or of the premium due. Sausen v. American Family Mutual Insurance Co. 121 Wis. 2d 653, 360 N.W.2d 565 (Ct. App. 1984).

This section governs cancellation and recision of insurance contracts. WHEDA v. Verex Assurance, Inc. 166 Wis. 2d 636, 480 N.W.2d 490 (1992).

The state was the policyholder of its employee group health policy and it, not the insureds, was entitled to notice of policy changes under sub. (5). Schaefer v. Physicians Plus Insurance Corp. 174 Wis. 2d 488, 497 N.W.2d 776 (Ct. App. 1993).

Sub. (5) requires notice of policy changes effected by the insurer, not changes effected by the legislature or the courts. Roehl v. American Family Mutual Insurance Co. 222 Wis. 2d 136, 585 N.W.2d 893 (Ct. App. 1998), 98−1207.

Under sub. (5), if an insurer offers to renew a policy on less favorable terms within 60 days of the renewal date, the insurer must inform the insured that the terms do not become effective until 60 days after the renewal is sent and that the insured has the same 60 days to cancel. Failure to comply requires the insurer to continue the prior policy terms for an additional period equal to the term of the expiring policy. Hanson v. Prudential Property & Casualty Insurance Co. 224 Wis. 2d 356, 591 N.W.2d 619 (Ct. App. 1999), 98−0692.

Sub. (5) does not apply to reducing clause changes that are not initiated by the insurer but come into effect by statutory change, even when the insurer gratuitously sends a renewal notice discussing the altered terms. Sukala v. Heritage Mutual Insurance Co. 2000 WI App 266, 240 Wis. 2d 65, 622 N.W.2d 457, 99−1339.

An insurer may effectively eliminate the policyholder's right to renewal if it provides valid notice of nonrenewal. If notice is not provided, the policyholder retains this right, and barring any application of an exception under sub. (4) (b), it may exercise its right to a renewal. Magyar v. Wisconsin Health Care Liability Insurance Plan, 2001 WI 41, 242 Wis. 2d 491, 625 N.W.2d 291, 98−3289.

Sub. (2) (c) contemplates 2 separate and distinct forms of notifying an insured of cancellation: postal mailing or personal delivery other than mailing. When the insurer informed the insured of its cancellation by mail, the trial court correctly measured the effective date of cancellation from the date of mailing. Schmitz v. Fire Insurance Exchange, 2005 WI App 76, 280 Wis. 2d 560, 696 N.W.2d 238, 04−1545.

631.37 Special cancellation provisions. The following cancellation provisions apply to the policies specified, whether or not s. 631.36 is also applicable to them.

(1) CANCELLATION UPON REQUEST OF PREMIUM FINANCE COMPANY. Section 138.12 (12) applies to cancellation on request of a premium finance company.

(2) CANCELLATION UPON REQUEST OF CREDITOR. Section 424.303 applies to cancellation upon request of a creditor.

(3) WORKER'S COMPENSATION INSURANCE. Sections 102.31 (2) and 102.315 (10) apply to the termination of worker's compensation insurance.

(3m) HEALTH CARE LIABILITY INSURANCE. Section 655.24 (2) (b), (3) and (4) applies to the termination of a health care liability insurance policy.

(4) SPECIAL LIMITATIONS ON CANCELLATION. (a) *School bus insurance.* Section 121.53 (4) applies to school bus insurance.

(b) *Insurance on common carriers.* Section 194.41 (2) applies to insurance on common carriers.

(c) *Driver education motor vehicles.* Section 341.267 (6) applies to motor vehicles used for driver education.

(d) *Insurance of juveniles.* Section 343.15 (4) (a) applies to motor vehicle policies covering juveniles as described therein.

(e) *Motor vehicle liability policy.* Section 344.34 applies to motor vehicle liability policies certified under s. 344.31.

(f) *Health care liability policy.* Section 655.25 applies to insurance issued by the mandatory health care liability risk−sharing plan established under s. 619.04.

(g) *Warranty reimbursement insurance policy.* Section 632.185 (2) (e) applies to warranty reimbursement insurance policies.

History: 1979 c. 102 ss. 165, 166; 1985 a. 83; 1989 a. 187; 1991 a. 315; 1993 a. 363; 2003 a. 302; 2007 a. 185; 2009 a. 245.

631.41 Policies jointly issued. Two or more insurers may together issue a policy in which their liability is either several or joint and several. If it is several, the heading of the policy shall conspicuously so state and the policy shall conspicuously state the proportion or amount of premium to be paid to each insurer and the type and the proportion or amount of liability each insurer agrees to assume.

History: 1975 c. 375.

631.43 Other insurance provisions. (1) GENERAL. When 2 or more policies promise to indemnify an insured against the same loss, no "other insurance" provisions of the policy may reduce the aggregate protection of the insured below the lesser of the actual insured loss suffered by the insured or the total indemnification promised by the policies if there were no "other insurance" provisions. The policies may by their terms define the extent to which each is primary and each excess, but if the policies contain inconsistent terms on that point, the insurers shall be jointly and severally liable to the insured on any coverage where the terms are inconsistent, each to the full amount of coverage it provided. Settlement among the insurers shall not alter any rights of the insured.

(2) FRAUD AS A DEFENSE. Subsection (1) does not affect the right of an insurer to defend against a claim under the policy on the ground of fraudulent misrepresentation.

(3) EXCEPTION. Subsection (1) does not affect the rights of insurers to limit, restrict, reduce, or exclude coverage under s. 632.32 (5) (b), (c), or (f) to (j).

History: 1975 c. 375; 1979 c. 102; 1995 a. 21; 2009 a. 28; 2011 a. 14.

NOTE: 1995 Wisconsin Act 21, which became effective on July 15, 1995, made significant changes in the law regarding the "stacking" of insurance policy coverage.

A clause providing that any amount payable under the insurer's policy would be reduced by monies paid by other insurance company's uninsured motorist coverage was not valid; therefore, the plaintiff was entitled to the entire benefits under both uninsured motorist provisions. Landvatter v. Globe Security Insurance Co. 100 Wis. 2d 21, 300 N.W.2d 875 (Ct. App. 1980).

An insurance policy provision that prohibits the stacking of uninsured motorist benefits against the same insurer is prohibited by sub. (1). Tahtinen v. MSI Insurance Co. 122 Wis. 2d 158, 361 N.W.2d 673 (1985).

Sub. (1) only prohibits the use of reducing clauses in indemnity coverages, not in underinsured motorist coverage. Kuehn v. Safeco Insurance Co. of America, 140 Wis. 2d 620, 412 N.W.2d 126 (Ct. App. 1987).

If a single insurance contract incorporates coverage for two vehicles, charging two separate premiums, two policies have been issued under s. 631.43. Krause v. Mass. Bay Insurance Co. 161 Wis. 2d 711, 468 N.W.2d 755 (Ct. App. 1991).

A fleet policy listing individual vehicles and assessing separate premiums for each is a separate policy for each vehicle and a single limit provision contained in the policy violates sub. (1). Carrington v. St. Paul Fire & Marine Insurance 169 Wis. 2d 211, 485 N.W.2d 267 (1992).

Carrington is extended to underinsured motorist coverage. An insured who pays separate premiums for each vehicle under a single policy can stack underinsured motorist coverage even though the policy contains a limit of liability clause. West Bend Mutual Insurance Co. v. Playman, 171 Wis. 2d 37, 489 N.W.2d 915 (1992).

Although a policy's limit of liability language has been held invalid under s. 631.43 for the purpose of preventing stacking, it is still valid for determining each policy's limit of liability. Schaefer v. General Cas. Co. 175 Wis. 2d 80, 498 N.W.2d 859 (Ct. App. 1993).

The lack of underinsured motorist coverage on an accident vehicle was irrelevant when the insured had the coverage on two other vehicles. Under sub. (1), a policy definition amounting to a "drive−other−car" exclusion is invalid. Rodey v. Stoner, 180 Wis. 2d 309, 509 N.W.2d 316 (Ct. App. 1993), Patraw v. American Family Mut. Ins. Co. 185 Wis. 2d 757, 519 N.W.2d 643 (Ct. App. 1994).

Liability coverages insuring against the risk of loss arising out of specified, owned vehicles do not insure against the same loss and thus sub. (1) does not apply to those coverages. Weimer v. Country Mutual Insurance Co. 211 Wis. 2d 848, 565 N.W.2d 595 (Ct. App. 1997), 96−1440.

The applicability of sub. (1) cannot be ascertained by resorting to historical definitions of indemnity and liability insurance. An analysis must be made of whether a particular policy promises to indemnify the insured against the same loss as another policy. Taylor v. Greatway Insurance Co. 2000 WI App 64, 233 Wis. 2d 703, 608 N.W.2d 722, 99−1329.

Sub. (1) did not invalidate a provision excluding coverage for a vehicle not owned by the driver but made regularly available to him when the owner's policy insured against losses arising from the use of the vehicle. The policies did not insure against the "same loss" within the meaning of sub. (1). Martin v. American Family Mutual Insurance Co. 2002 WI 40, 252 Wis. 2d 103, 643 N.W.2d 452, 00−2344.

Section 632.05 (2), the valued policy law, does not provide that an insured is entitled to the limits of all policies insuring a dwelling. Instead, sub. (1), the pro rata statute, specifically governs situations when two or more policies indemnify against the same loss. Absent the consent of the insurers, insureds are entitled to the full amount of their loss but not to the full amount of both policies if the combined limits exceed the actual loss. Wegner v. West Bend Mutual Insurance Company, 2007 WI App 18, 298 Wis. 2d 420, 728 N.W.2d 30, 05−3193.

Sub. (1) refers specifically to "other insurance" provisions. The accepted meaning of "other insurance" provisions does not include application to successive insurance policies. "Other insurance" refers only to two or more policies insuring the same risk, and the same interest, for the benefit of the same person, during the same period. The issue here was not which of two or more policies pays first, because they were not concurrent policies between competing insurers that applied to the same time period, but successive policies from the same insurer. Plastics Engineering Co. v. Liberty Mutual Insurance Co. 2009 WI 13, 315 Wis. 2d 556, 759 N.W.2d 613, 08−0333.

Stacking uninsured motorist coverage. Hannula, WBB Oct. 1985.

631.45 Limitations on loss to be borne by insurer. **(1)** GENERAL. An insurance policy indemnifying an insured against loss may by clear language limit the part of the loss to be borne by the insurer to a specified or determinable maximum amount, to loss in excess of a specified or determinable amount, to a specified percentage of the loss, which may vary with the amount of the loss, or by a combination of these methods. If the policy covers various risks, different limitations may be provided separately for each risk if the policy clearly so states.

(2) PROPERTY COINSURANCE. A policy indemnifying an insured against loss of or damage to property may limit the part of the loss to be borne by the insurer to a percentage of the total loss that corresponds to the ratio of the insured sum to a specified percentage of the value of the insured property.

History: 1975 c. 375.

Public policy does not prohibit insurance coverage for statutorily imposed multiple damages. Cieslewicz v. Mutual Service Casualty Insurance Co. 84 Wis. 2d 91, 267 N.W.2d 595 (1978).

Under the facts of the case, the insurer's tender of the policy limits into court did not relieve the insurer of its duty to defend the insured in the lawsuit. Gross v. Lloyds of London Insurance Co. 121 Wis. 2d 78, 358 N.W.2d 266 (1984).

Although a policy's limit of liability language has been held invalid under s. 631.43 for the purpose of preventing stacking, it is still valid for determining each policy's limit of liability. Schaefer v. General Cas. Co. 175 Wis. 2d 80, 498 N.W.2d 859 (Ct. App. 1993).

631.48 Nonwaiver clause. An insurer may insert in any insurance policy a provision that no change in the policy is valid unless approved by an executive officer of the insurer, or unless the approval is endorsed on the policy or attached to it, or both, and that no agent has authority to change the policy or waive any of its provisions. This does not preclude a person claiming a right under the policy from relying on waiver or estoppel in an appropriate case.

History: 1975 c. 375.

631.51 Dividends on policies. **(1)** LIFE INSURANCE AND ANNUITIES. Section 632.62 applies to life insurance and annuities.

(2) INSURANCE, OTHER THAN LIFE INSURANCE AND ANNUITIES. Any insurer may distribute a portion of surplus attributable to policies other than life insurance or annuities, in amounts and with classifications the board of directors determines to be fair and reasonable. Such distribution may not be made contingent on the continuation of the policy or of premium payments except under s. 632.75 (2). A schedule explaining the basis for the distribution shall be filed with the commissioner prior to the distribution.

(3) WHEN NOT SPECIFIED IN POLICY. Any insurer may distribute surplus to any class of policyholders even if those policies do not so provide. A schedule explaining the basis for the distribution shall be filed with the commissioner at least 30 days prior to the distribution.

(4) COMBINED DIVIDENDS. It is permissible to provide an indivisible dividend to classes of policyholders having more than one type of policy, including a combination of life or annuities with other types of insurance.

History: 1975 c. 375.

631.61 Group and blanket insurance. **(1)** CERTIFICATES. (a) *General.* Except under par. (d), an insurer issuing a group insurance policy other than blanket shall, as soon as practicable after the coverage is effective, provide a certificate for each member of the insured group, except that only one certificate need be provided for the members of a family unit. The certificate shall contain a summary of the essential features of the insurance coverage, including any rights of conversion to an individual policy. Upon receiving a written request therefor, the insurer shall also inform any insured how the insured may inspect a copy of the policy during normal business hours at a place reasonably convenient to the insured.

(b) *Blanket insurance.* The commissioner may by rule impose a similar requirement for any class of blanket insurance policies for which the commissioner finds that the group of persons covered is constant enough for such action to be practicable and not unreasonably expensive.

(c) *Method of providing certificates.* The certificate shall be provided in a manner reasonably calculated to bring it to the attention of the certificate holder. The insurer may deliver or mail it directly to the certificate holder or may deliver or mail the certificates in bulk to the policyholder to transmit to certificate holders, unless the insurer has reason to believe that the policyholder will not promptly transmit the certificates. An affidavit by the insurer that it has mailed the certificates in the usual course of business creates a rebuttable presumption that it has done so. As an alternative to delivering or mailing the certificate, the insurer may make the certificate available electronically through an online internet or policyholder network Web site. If the insurer makes the certificate available electronically, the insurer shall do all of the following:

1. Request the policyholder to post the information, as well as instructions on how to access the certificate, in the policyholder's place of business or to publish the information and access instructions in a house organ that is reasonably calculated to bring the information to the attention of the certificate holders.

2. Provide notice to the policyholder of any subsequent change in the certificate and request the policyholder to notify the certificate holders of the change in the manner specified in subd. 1.

3. Provide a paper copy of the certificate to any certificate holder upon request.

(d) *Substitutes.* The commissioner may by rule or order prescribe substitutes for delivery or mailing of certificates, including booklets describing the coverage, the posting of notices in the place of business, or publication in a house organ, if the substitutes are reasonably calculated to inform certificate holders of their rights.

(2) EFFECT OF FAILURE TO ISSUE CERTIFICATES. Unless a certificate or an authorized substitute has been made available to the certificate holder as required by this section, no act or omission by the certificate holder after the coverage has become effective as to the certificate holder, other than intentionally causing the loss insured against, affects the insurer's obligations under the insurance contract.

History: 1975 c. 375, 421; 2007 a. 170.

631.64 Corporate name. Every insurance policy or annuity contract shall conspicuously display the name of the insurer on its first page.

History: 1975 c. 375.

631.65 Assessable policies. Every assessable policy shall conspicuously display on the first page, separately from any other provision and in type at least as large as any used in the body of the policy, the words "This policy is assessable".

History: 1975 c. 375; 1981 c. 218.

631.69 Insurance written in connection with finance plans. Any insurance contract written in connection with a finance plan or other credit transaction shall contain provisions to

protect the insured from overreaching by the insurer or by the creditor in connection with the insurance, including a provision that a copy of the complete policy or a certificate containing all of the essential terms be furnished to the debtor and that there shall be an appropriate surrender value or refund of unearned premium to the debtor calculated on a basis approved by the commissioner if the debt is paid or if the insurance contract is rewritten because the original finance plan or credit transaction is altered or a new plan or transaction is entered into with the same or an affiliated lender. This section is satisfied by compliance with the terms of ch. 424, if they are applicable.

History: 1975 c. 375.

631.81 Notice and proof of loss. (1) TIMELINESS OF NOTICE. Provided notice or proof of loss is furnished as soon as reasonably possible and within one year after the time it was required by the policy, failure to furnish such notice or proof within the time required by the policy does not invalidate or reduce a claim unless the insurer is prejudiced thereby and it was reasonably possible to meet the time limit.

(2) METHOD OF GIVING NOTICE. It is a sufficient service of notice or proof of loss if a 1st class postage prepaid envelope addressed to the insurer and containing the proper notice or proof is deposited in any U.S. post office within the time prescribed. The commissioner may expressly approve clauses requiring more expeditious methods of notice where that is reasonable.

(3) MEANING OF INSURER'S ACTS. The acknowledgment by the insurer of the receipt of notice, the furnishing of forms for filing proofs of loss, the acceptance of such proofs, or the investigation of any claim are not alone sufficient to waive any of the rights of the insurer in defense of any claim arising under the insurance contract.

History: 1975 c. 375.

An insured's contradictory statements constituted a breach of the contractual duties of notice and cooperation. Dietz v. Hardware Dealers Mutual Fire Insurance Co. 88 Wis. 2d 496, 276 N.W.2d 808 (1979).

When the insured fails to give notice within one year after the time required in the policy, there is a rebuttable presumption of prejudice, and the burden of proof shifts to the claimant to prove that the insurer was not prejudiced. Neff v. Pierzina, 2001 WI 95, 245 Wis. 2d 285, 629 N.W.2d 177, 99−1069.

The Federal Employee Retirement Income Security Act (ERISA) preempts state law related to any covered employee benefit plan, but does not preempt state regulation of insurance. This section regulates insurance and is not preempted. Bogusewski v. Life Insurance Co. of North America, 977 F. Supp. 1357 (1997).

An insurer is prejudiced by late notice when it has been denied the opportunity to have input into how the underlying claim is being defended. An insured may not assume that if its insurer had been given the opportunity to make a timely investigation, it would have produced the same result as that produced by the insured's own investigation or that any discovery that the insurer would have conducted would parallel that already conducted by the insured. Phoenix Contractors, Inc. v. Affiliated Capital Corporation, 2004 WI App 103, 273 Wis. 2d 736, 681 N.W.2d 310, 03−2259.

Wisconsin's notice−prejudice statutes, this section and s. 632.26, do not supersede the reporting requirement specific to claims−made−and−reported policies. Anderson v. Aul, 2015 WI 19, 361 Wis. 2d 63, 862 N.W.2d 304, 13−0500.

631.83 Limitation of actions. (1) STATUTORY PERIODS OF LIMITATION. (a) *Fire insurance.* An action on a fire insurance policy must be commenced within 12 months after the inception of the loss. This rule also applies to riders or endorsements attached to a fire insurance policy covering loss or damage to property or to the use of or income from property from any cause, and to separate windstorm or hail insurance policies.

(b) *Disability insurance.* An action on disability insurance coverage must be commenced within 3 years from the time written proof of loss is required to be furnished.

(c) *Life claims based on absence of insured.* Sections 813.22 to 813.34 apply to life insurance actions based on death in which absence is relied upon as evidence of death.

(d) *Other.* Except as provided in this subsection or elsewhere in chs. 600 to 646 and 655, s. 893.43 applies to actions on insurance policies.

(2) GENERAL LAW APPLICABLE TO LIMITATION OF ACTIONS. Except for the prescription of time periods under sub. (1) or elsewhere in chs. 600 to 646 and 655, the general law applicable to limitation of actions as modified by ch. 893 applies to actions on insurance policies.

(3) PROHIBITED CLAUSES OF POLICIES. No insurance policy may:

(a) *Shorten periods of limitation.* Limit the time for beginning an action on the policy to a time less than that authorized by the statutes;

(b) *Limit jurisdiction.* Prescribe in what court action may be brought thereon; or

(c) *Proscribe action.* Provide that no action may be brought.

(4) MINIMUM WAITING PERIOD FOR ACTION. No action may be brought against the insurer on an insurance policy to compel payment thereunder until at least 60 days after proof of loss has been furnished as required by the policy or such proof of loss has been waived, or the insurer has denied full payment, whichever is earlier. This subsection does not apply in any case in which the verified complaint alleges facts that would establish prejudice to the complainant by reason of such delay, other than the delay itself.

(5) TOLLING OF PERIOD OF LIMITATION. The period of limitation is tolled during the period in which the parties conducted an appraisal or arbitration procedure prescribed by the insurance policy or by law or agreed to by the parties.

History: 1975 c. 375; 1979 c. 89, 102; 1983 a. 192; 1987 a. 247; 1989 a. 187 s. 29.

The term "fire insurance" covers indemnity insurance for losses to property caused by many perils other than fire. Villa Clement v. National Union Fire Insurance Co. of Pittsburgh, 120 Wis. 2d 140, 353 N.W.2d 369 (Ct. App. 1984).

Action by mortgagees of insured property against the insurer for paying the policy proceeds to the insured despite knowledge of the mortgagee's interest was not on the policy and was not barred by sub. (1) (a). Picus v. Citizens Security Mutual Insurance Co. 127 Wis. 2d 359, 379 N.W.2d 341 (Ct. App. 1985).

The s. 893.57 statute of limitations governs the intentional tort of bad faith by an insurer. Warmka v. Hartland Cicero Mutual Insurance Co. 136 Wis. 2d 31, 400 N.W.2d 923 (1987).

"Inception of the loss" in sub. (1) (a) means the date on which the loss occurs, not the discovery date. Borgen v. Economy Preferred Ins. Co. 176 Wis. 2d 498, 500 N.W.2d 176 (Ct. App. 1993).

The failure of policyholders to give notice to an underinsurer of a settlement between the insured and the tortfeasor did not bar underinsured motorist coverage in the absence of prejudice to the insurer. There is a rebuttable presumption of prejudice when there is a lack of notice, with the burden on the insured to prove by the greater weight of the evidence that the insurer was not prejudiced. Ranes v. American Family Mutual Insurance Co. 219 Wis. 2d 49, 580 N.W.2d 197 (1998), 97−0441.

Sub. (2) clearly and unambiguously excepts the time limitations for fire insurance claims from the application of s. 893.12. Wieting Funeral Home of Chilton, Inc. v. Meridian Mutual Insurance Co. 2004 WI App 218 277 Wis. 2d 274, 690 N.W.2d 442, 04−0461.

An "agreement" by the parties to engage in an appraisal procedure under sub. (5) requires something more than a mere agreement to meet and discuss a dispute between the parties. Wieting Funeral Home of Chilton, Inc. v. Meridian Mutual Insurance Co. 2004 WI App 218, 277 Wis. 2d 274, 690 N.W.2d 442, 04−0461.

The key word in sub. (1) (a) is not loss, but inception. In a claim arising from damage to corn yield resulting from vandalism to a corn planter, the inception of that loss was the moment overfertilized seeds were planted with the vandalized corn planter. Bronsteatter & Sons, Inc. v. American Growers Insurance Company, 2005 WI App 192, 286 Wis. 2d 782, 703 N.W.2d 757, 05−0115.

Because all of the statutory language surrounding sub. (5), including the statute regulating arbitration and appraisals, applies only to first−party claims, sub. (5) tolls the period of limitation only as to claims by insureds against their insurer, not to claims by third parties against a tortfeasor's insurer. Thom v. OneBeacon Insurance Company, 2007 WI App 123, 300 Wis. 2d 607, 731 N.W.2d 657, 06−1617.

631.85 Appraisal or arbitration. An insurance policy may contain provisions for independent appraisal and compulsory arbitration, subject to the provisions of s. 631.20. If an approved policy provides for application to a court of record for the appointment of a disinterested appraiser, arbitrator, or umpire, any court of record of this state except the court of appeals or the supreme court may be requested to make an appointment. Upon appropriate request, the court shall make the appointment promptly. This section does not apply to a surplus lines insurance form issued under s. 618.41 before, on, or after April 20, 2012.

History: 1975 c. 375; 1977 c. 187; 2011 a. 224.

Although s. 631.20 generally refers to forms, its procedure for approval of forms is applicable to arbitration clauses under this section. An arbitration clause not approved under this section is per se invalid. Appleton Papers, Inc. v. Home Indemnity Co. 2000 WI App 104, 235 Wis. 2d 39, 612 N.W.2d 760, 99−1567.

631.89 Restrictions on use of genetic test results. (1) In this section, "genetic test" means a test using deoxyribonucleic acid extracted from an individual's cells in order to determine the presence of a genetic disease or disorder or the individual's predisposition for a particular genetic disease or disorder.

(2) An insurer, the state with respect to a self−insured health plan, or a county, city, village or school board that provides health care services for individuals on a self−insured basis, may not do any of the following:

(a) Require or request directly or indirectly any individual or a member of the individual's family to obtain a genetic test.

(b) Require or request directly or indirectly any individual to reveal whether the individual or a member of the individual's family has obtained a genetic test or what the results of the test, if obtained by the individual or a member of the individual's family, were.

(bm) Require or request directly or indirectly a health care provider, as defined in s. 146.81 (1) (a) to (p), who is or may be providing or who has or may have provided health care services to an individual to reveal whether the individual or a member of the individual's family has obtained a genetic test or what the results of the test, if obtained by the individual or a member of the individual's family, were.

(c) Condition the provision of insurance coverage or health care benefits on whether an individual or a member of the individual's family has obtained a genetic test or what the results of the test, if obtained by the individual or a member of the individual's family, were.

(d) Consider in the determination of rates or any other aspect of insurance coverage or health care benefits provided to an individual whether an individual or a member of the individual's family has obtained a genetic test or what the results of the test, if obtained by the individual or a member of the individual's family, were.

(3) (a) Subsection (2) does not apply to an insurer writing life insurance coverage or income continuation insurance coverage.

(b) An insurer writing life insurance coverage or income continuation insurance coverage that obtains information under sub. (2) (a) or (b) may not do any of the following:

1. Use the information contrary to sub. (2) (c) or (d) in writing a type of insurance coverage other than life or income continuation for the individual or a member of the individual's family.

2. Provide for rates or any other aspect of coverage that is not reasonably related to the risk involved.

History: 1991 a. 269; 1997 a. 74; 2009 a. 28.

631.90 Restrictions on use of tests for HIV. (1) In this section, "HIV test" has the meaning given in s. 252.01 (2m).

(2) With regard to policies issued or renewed on and after July 20, 1985, an insurer may not do any of the following:

(a) Require or request directly or indirectly any individual to reveal whether the individual has obtained an HIV test or what the results of this test, if obtained by the individual, were.

(b) Condition the provision of insurance coverage on whether an individual has obtained an HIV test or what the results of this test, if obtained by the individual, were.

(c) Consider in the determination of rates or any other aspect of insurance coverage provided to an individual whether an individual has obtained an HIV test or what the results of this test, if obtained by the individual, were.

(3) (a) Subsection (2) does not apply with regard to an HIV test for use in the underwriting of individual life, accident and health insurance policies that the commissioner finds and designates by rule as sufficiently reliable for use in the underwriting of individual life, accident and health insurance policies.

(b) Paragraph (a) does not authorize the use of an HIV test to discriminate in violation of s. 628.34 (3).

History: 1985 a. 29, 73; 1987 a. 70 ss. 34, 36; 1989 a. 201 ss. 31, 36; 1995 a. 27 s. 9126 (19); 2007 a. 20 s. 9121 (6) (a); 2009 a. 209.

Cross−reference: See also s. Ins 3.53, Wis. adm. code.

631.93 Prohibited provisions concerning HIV infection. (1) DEFINITIONS. In this section, "HIV infection" means the pathological state produced by a human body in response to the presence of HIV, as defined in s. 631.90 (1).

(2) ACCIDENT AND HEALTH INSURANCE. An accident or health insurance policy may not contain exclusions or limitations, including deductibles or copayments, for coverage of the treatment of HIV infection or any illness or medical condition arising from or related to HIV infection, unless the exclusions or limitations apply generally to other illnesses or medical conditions covered by the policy.

(3) LIFE INSURANCE. A life insurance policy may not deny or limit benefits solely because the insured's death is caused, directly or indirectly, by HIV infection or any illness or medical condition arising from or related to HIV infection.

History: 1989 a. 201.

631.95 Restrictions on insurance practices; domestic abuse. (1) DEFINITIONS. In this section:

(a) "Abuse" has the meaning given in s. 813.122 (1) (a).

(b) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(c) "Domestic abuse" has the meaning given in s. 968.075 (1) (a).

(2) GENERAL PROHIBITIONS. Except as provided in sub. (3), an insurer may not do any of the following:

(a) Refuse to provide or renew coverage to a person, or cancel a person's coverage, under an individual or group insurance policy or a certificate of group insurance on the basis that the person has been, or the insurer has reason to believe that the person is, a victim of abuse or domestic abuse or that a member of the person's family has been, or the insurer has reason to believe that a member of the person's family is, a victim of abuse or domestic abuse.

(b) Refuse to provide or renew coverage to an employer or other group, or cancel an employer's or other group's coverage, under a group insurance policy on the basis that an employee or other group member has been, or the insurer has reason to believe that an employee or other group member is, a victim of abuse or domestic abuse or that a member of an employee's or other group member's family has been, or the insurer has reason to believe that a member of an employee's or other group member's family is, a victim of abuse or domestic abuse.

(c) Use as a factor in the determination of rates or any other aspect of insurance coverage under an individual or group insurance policy or a certificate of group insurance the knowledge or suspicion that a person or an employee or other group member has been or is a victim of abuse or domestic abuse or that a member of the person's or an employee's or other group member's family has been or is a victim of abuse or domestic abuse.

(d) Under an individual or group disability insurance policy or a certificate of group disability insurance, exclude or limit coverage of, or deny a claim for, health care services or items related to the treatment of injury or disease resulting from abuse or domestic abuse on the basis that a person or an employee or other group member has been, or the insurer has reason to believe that a person or an employee or other group member is, a victim of abuse or domestic abuse or that a member of the person's or an employee's or other group member's family has been, or the insurer has reason to believe that a member of the person's or an employee's or other group member's family is, a victim of abuse or domestic abuse.

(e) Under an individual or group life insurance policy or a certificate of group life insurance, deny or limit benefits in the event that the death of the person whose life is insured results from abuse or domestic abuse on the basis that the person whose life is insured has been, or the insurer has reason to believe that the person whose life is insured is, a victim of abuse or domestic abuse or that a member of the family of the person whose life is insured has been, or the insurer has reason to believe that a member of the family of the person whose life is insured is, a victim of abuse or domestic abuse.

(f) Under property insurance coverage that excludes coverage for loss or damage to property resulting from intentional acts, deny payment to an insured for a claim based on property loss or damage resulting from an act, or pattern, of abuse or domestic abuse if that insured did not cooperate in or contribute to the creation of the loss or damage and if the person who committed the act or acts that caused the loss or damage is criminally prosecuted for the act or acts. Payment to the innocent insured may be limited in accordance with his or her ownership interest in the property or reduced by payments to a mortgagee or other holder of a secured interest.

(3) EXCEPTIONS AND QUALIFICATIONS RELATED TO PROHIBITIONS. (a) *Disability insurance.* In establishing premiums for an individual or group disability insurance policy or a certificate of group disability insurance, an insurer may inquire about a person's existing medical condition and, based on the opinion of a qualified actuary, as defined in s. 623.06 (1) (h), use information related to a person's existing medical condition, regardless of whether that condition is or may have been caused by abuse or domestic abuse.

(b) *Life insurance.* With respect to an individual or group life insurance policy or a certificate of group life insurance, an insurer may, on the basis of information in medical, law enforcement or court records, or on the basis of information provided by the insured, policyholder or applicant for insurance, do any of the following:

1. Deny or limit benefits under such a policy or certificate to a beneficiary who is the perpetrator of abuse or domestic abuse that results in the death of the insured.

2. Refuse to issue such a policy or certificate that names as a beneficiary a person who is or was, or who the insurer has reason to believe is or was, a perpetrator of abuse or domestic abuse against the person who is to be the insured under the policy.

3. Refuse to name as a beneficiary under such a policy or certificate a person who is or was, or who the insurer has reason to believe is or was, a perpetrator of abuse or domestic abuse against the insured under the policy.

4. Refuse to issue such a policy or certificate to a person who is or was, or who the insurer has reason to believe is or was, a perpetrator of abuse or domestic abuse against the person who is to be the insured under the policy.

5. Refuse to issue such a policy or certificate to a person who lacks an insurable interest in the person who is to be the insured under the policy.

6. For purposes of underwriting; administering a claim under; or determining a person's eligibility for coverage, a benefit or payment under; such a policy or certificate; or for purposes of servicing such a policy or certificate or an application for such a policy or certificate; inquire about and use information related to a person's medical history or existing medical condition, regardless of whether that condition is or may have been caused by abuse or domestic abuse. Any adverse underwriting decision based on a person's medical history or medical condition must be made in conformity with sound actuarial principles or otherwise supported by actual or reasonably anticipated experience.

(c) *Disability income or long−term care insurance.* With respect to an individual or group disability income or long−term care insurance policy or a certificate of group disability income or long−term care insurance, an insurer may, on the basis of information in medical, law enforcement or court records, or on the basis of information provided by the insured, policyholder or applicant for insurance, do any of the following:

1. Refuse to name as a beneficiary under such a policy or certificate a person who is or was, or who the insurer has reason to believe is or was, a perpetrator of abuse or domestic abuse against the insured under the policy.

2. Refuse to issue such a policy or certificate to a person who is or was, or who the insurer has reason to believe is or was, a perpetrator of abuse or domestic abuse against the person who is to be the insured under the policy.

3. Refuse to issue such a policy or certificate to a person who lacks an insurable interest in the person who is to be the insured under the policy.

4. For purposes of underwriting; administering a claim under; or determining a person's eligibility for coverage, a benefit or payment under; such a policy or certificate; or for purposes of servicing such a policy or certificate or an application for such a policy or certificate; inquire about and use information related to a person's medical history or existing medical condition, regardless of whether that condition is or may have been caused by abuse or domestic abuse. Any adverse underwriting decision based on a person's medical history or medical condition must be made in conformity with sound actuarial principles or otherwise supported by actual or reasonably anticipated experience.

(4) IMMUNITY FOR INSURERS. An insurer is immune from any civil or criminal liability for any action taken under sub. (3) or for the death of, or injury to, an insured that results from abuse or domestic abuse.

(5) USE AND DISCLOSURE OF ABUSE INFORMATION. (a) Except as provided in pars. (c) and (d) and sub. (3), no person employed by or contracting with an insurer may use, disclose or transfer information related to any of the following:

1. Whether an insured or applicant for insurance or a member of the insured's or applicant's family, or whether an employee or other group member of an insured or applicant for insurance or a member of the employee's or other group member's family, is or has been, or is with reason believed by the person employed by or contracting with the insurer to be or to have been, a victim of abuse or domestic abuse.

2. Whether an insured or applicant for insurance, or whether an employee or other group member of an insured or applicant for insurance, is a family member or associate of, or in a relationship with, a person who is or has been, or who the person employed by or contracting with the insurer has reason to believe is or has been, a victim of abuse or domestic abuse.

3. Whether an insured or an applicant for insurance employs a person who is or has been, or who the person employed by or contracting with the insurer has reason to believe is or has been, a victim of abuse or domestic abuse.

(b) Except as provided in pars. (c) and (d), a person employed by or contracting with an insurer may not disclose or transfer information related to the telephone number or address or other location of any of the following individuals, if the person knows that the individual is or has been, or has reason to believe that the individual is or has been, a victim of abuse or domestic abuse:

1. An insured.

2. An applicant for insurance.

3. An employee of an insured or of an applicant for insurance.

4. A group member of an insured or of an applicant for insurance.

5. A member of the family of any of the individuals listed in subds. 1. to 4.

(c) Paragraphs (a) and (b) do not apply if the use, disclosure or transfer of the information is made with the consent of the individual to whom the information relates or if the use, disclosure or transfer satisfies any of the following:

1. Is for a purpose related to the direct provision of health care services.

2. Is for a valid business purpose, including the disclosure or transfer of the information to any of the following:

a. A reinsurer.

b. A party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer.

c. Medical, underwriting or claims personnel under contract or affiliated with the insurer.

d. An attorney representing the interests of the insurer.

e. The policyholder or policyholder's assignee as a result of delivery of the policy.

3. Is in response to legal process.

4. Is required by a court order or an order of an entity with authority to regulate insurance, or is otherwise required by law.

5. Is required or authorized by the commissioner by rule.

(d) Nothing in this subsection limits or precludes an insured or an applicant for insurance, or an employee or other group member of an insured or applicant for insurance, from obtaining his or her own insurance records from an insurer.

History: 1999 a. 95; 2015 a. 90.