CHAPTER 204.

INSURANCE—SURETY, CREDIT, CASUALTY.

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204.01 Definitions. The fidelity insurance specified in subsection (7) of section 201.04 shall be known as surety business, and the obligations connected therewith as suretyship obligations; and corporations organized or authorized to do surety business are designated surety corporations or companies.

204.02 Surety companies. (1) LICENSE. When the commissioner shall be satisfied by the papers filed or by such examination as he shall make, that any surety company applying for a license has fully complied with and has the capital and surplus required by the statutes, he shall issue a certificate under his hand and official seal authorizing it to transact surety business. The certificate may also cover any other kinds of insurance which the company has power to transact.

(2) OLD COMPANIES. Any domestic corporation which on July 25, 1919, had power to transact surety business shall be entitled to such certificate if its capital, surplus and deposit at the time of the application for the certificate are not less than the sums respectively required of such corporation immediately prior to said date.

(3) LICENSE, DURATION, RENEWAL. The certificate shall expire on the thirtieth day of April next following its effective date and may be renewed from year to year; the commissioner shall have the same power to refuse to renew a certificate that he has to deny an original certificate.

(4) EVIDENCE, SOLVENCY. Such certificate and certified copies thereof shall be evidence of the qualification of the company named therein to do surety business and to be accepted as surety on all instruments as provided in this chapter, and of the solvency of such company and shall be equivalent to the justification required of sureties.

204.03 Failure to file license. No instrument executed by a licensed surety company shall be held invalid or ineffective because such certificate or a certified copy thereof has not been filed; but the officer with whom any instrument so executed has been filed or any person who might claim the benefit thereof may require the person filing such instrument to file with such officer a certified copy of the surety's certificate of authority by giving him written notice so to do, and if he shall fail to file the same within eight days thereafter said instrument shall be of no effect for the purposes of the person filing the same unless he shall, before the expiration of such time, file such other bond, undertaking or instrument as was originally required.

204.04 Licenses. (1) MAILING, FILING COPY. Upon the request of any surety company that a certified copy of its certificate of authority be furnished to any designated officer in this state and upon the payment of the fee required by law, the commissioner shall mail such copy to the designated officer who shall file the same. In case of revocation of the certificate of authority the commissioner shall immediately give notice thereof to each officer to whom a certified copy shall have been forwarded.

(2) EFFECT OF FILING COPY. Whenever a certified copy shall have been furnished to any public officer it shall be unnecessary, during the life of such certificate, to attach a copy thereof to any bond, undertaking or other instrument of suretyship filed with him.

(3) NOTICE OF INSOLVENCY TO COURTS. Whenever the commissioner shall learn that any licensed surety company has become financially embarrassed or unreasonably fails to carry out its contracts, or has filed a petition in bankruptcy, or is in the hands of a receiver, he shall immediately notify every county judge and the clerks of all courts of record in this state of said facts; and upon the receipt of such notice it shall be the duty of county judges and clerks of courts of record to notify and require every executor, administrator, guardian, trustee or other fiduciary that has filed a bond on which such company is surety, to forthwith file a new bond with new sureties.

204.041 Domestic corporations, capital and surplus required. No domestic corporation hereafter organized shall be authorized to commence the transaction of the surety business in this state unless it has a capital stock, if a stock corporation of at least two hundred and fifty thousand dollars and a surplus of at least one hundred and twenty-five thousand dollars, both fully paid in cash, or a surplus, if a mutual corporation, of at least three hundred and seventy-five thousand dollars. No domestic insurance corporation authorized in this state to transact other classes of insurance shall hereafter be authorized to transact the surety business unless in addition to the capital stock and surplus requirements for the classes of insurance being transacted by such corporation, it shall also have a capital of at least two hundred fifty thousand dollars and a surplus of at least one hundred and twenty-five thousand dollars, if a stock corporation, or a surplus of three hundred and seventy-five thousand dollars, if a mutual corporation.

204.05 Foreign surety corporations, capital surplus. (1) No foreign corporation shall be authorized to transact surety business in this state unless at the time of its application for authority it has an unimpaired capital and surplus if a stock corporation, and a surplus, if a mutual corporation equal to that required of a similar domestic corporation. No corporation organized under the laws of a foreign country shall be authorized to transact surety business unless it shall satisfy the commissioner that it has on deposit with American trustees, or with the proper officers of states of the United States, or both, satisfactory securities equal in value to the total of the initial capital and surplus required of a similar domestic corporation, and that such securities are held in trust for the fulfillment by such company of all its obligations within the United States.

(2) A foreign corporation, applying for admission to transact surety business, shall before admission file with the commissioner, in addition to what is required by section 201.32, an agreement, properly signed, that it will not transact in this state any business which a similar domestic corporation is prohibited from transacting.

204.06 Corporations deposit securities. (1) No domestic corporation shall transact surety business unless it shall deposit and keep on deposit with the state treasurer securities specified in section 209.01 (3) worth, at their market value, not less than $100,000, and, in case such corporation transacts such business in other states, its total deposits shall be at least $250,000.

(2) No corporation incorporated under the laws of any other state or possession of the United States shall be authorized to transact surety business unless it shall satisfy the commissioner that it has on deposit with the proper officers of states or possessions of the United States, satisfactory securities worth, at their market value, at least two hundred and fifty thousand dollars. The securities so deposited in this state or elsewhere shall be held in trust for the fulfillment by the depositor of all of its obligations in the United States. No deposit shall be required of a surety corporation organized under the laws of a foreign country, other than the deposit required by section 204.05.

(3) No additional deposit shall be required of an insurance company, transacting other classes of insurance, as a condition of its engaging in the surety business; provided, that the securities it has on deposit in this state or elsewhere satisfy the requirements of subsection (1), and are held in trust for the fulfillment by the depositor of its contracts, whether of insurance or of suretyship, within the United States.

(4) The securities deposited pursuant to this section shall be held, exchanged, withdrawn, disposed of and the interest therefrom be paid to the corporation making the

deposit as provided in section 209.01; provided, the total market value of the securities on deposit shall not fall below the minimum required by this section.

204.07 Suretyship obligations. A licensed surety corporation may guarantee the conditions of or execute any bond, undertaking or obligation which is required or permitted by law to be given for the security of any person, association, corporation, state, county, municipality or other organization, or conditioned for the doing or not doing of anything specified in any such instrument; and all public officers, boards and committees, and all courts, judges and magistrates may accept and approve such instruments when executed or the conditions thereof are guaranteed by a licensed surety corporation. Such execution or guarantee shall be a full and complete compliance with all requirements as to how and by whom such instruments shall be executed or guaranteed. Such corporation may execute or guarantee any such instrument given under the laws of the United States or of any other state or country. Suretyship obligations need not be under seal unless the law specifically requires a seal and may be executed by any officer, attorney in fact or other authorized representative.

204.08 Fidelity obligations specified. A surety corporation licensed to write the fidelity insurance specified in subsection (7) of section 201.04 may guarantee the fidelity of or become surety for (a) persons holding positions of public or private trust, (b) the performance of any act, duty or obligation or the refraining from any act, (c) the performance of any contract, (d) bonds of insurance companies required by law as a condition of transacting business, (e) indemnifying banks, brokers and other financial or moneyed associations or corporations, against the loss of documents and money, except against loss caused by marine risks or risks of transportation or navigation, (f) indemnifying any federal land bank againt loss by reason of defective title to or incumbrances on real property on which such bank may have a mortgage.

204.09 Guarantee's protection of guarantor. Any surety corporation may contract for indemnity or security for any suretyship obligation incurred by it; and any fiduciary from whom a suretyship obligation is required or permitted by law may deposit any moneys and other property for which he is responsible with a bank, safe deposit or trust company, in such manner as to prevent the withdrawal or alienation thereof without the written consent of the surety or an order of a court or judge thereof having jurisdiction of such fiduciary, made on such notice to the surety as the court or judge may direct.

204.10 Limitation of risks; reinsurance. (1) No corporation shall execute any suretyship obligation or expose itself to any loss on any one risk in an amount in excess of one-tenth of its capital and surplus, unless it shall be protected in the excess of that amount: (a) By reinsurance in a corporation authorized to transact surety business where the risk is located; provided, that such reinsurance is in such form as to enable the obligee in or beneficiary of such suretyship obligation to maintain an action thereon jointly against the company reinsured and such reinsurer and to have recovery against such reinsurer for payment to the extent in which it may be liable under such reinsurance; or (b) by the cosuretyship of a surety corporation likewise authorized; or (c) by deposit with it in pledge or conveyance to it in trust for its protection of property; or (d) by conveyance or mortgage for its protection; or (e) in case such suretyship obligation was made on behalf or on account of a fiduciary by deposit of a portion of the trust property under the conditions specified in section 204.09.

(2) But a surety corporation may execute transportation or warehousing bonds for United States internal revenue taxes to an amount equal to fifty per cent of its capital and surplus.

(3) When the penalty of the suretyship obligation exceeds the amount of a judgment described therein as appealed from and thereby secured, or exceeds the amount of the subject matter in controversy or of the estate in the hands of the fiduciary for the performance of whose duties it is conditioned, the suretyship obligation may be executed, if the actual amount of the judgment or the subject matter in controversy or estate not subject to supervision or control of the surety is not in excess of the one-tenth limitation; and when the penalty of the suretyship obligation executed for the performance of a contract exceeds the contract price, the latter shall be taken as the basis for estimating the limit of risk.

(4) No such corporation shall guarantee the deposits of any single financial institution in an aggregate amount in excess of one-tenth of its capital and surplus unless it shall be protected in excess of that amount by credits in accordance with subsection (1).

204.11 Premium on bond allowed as expense. (1) Any fiduciary required to give a suretyship obligation may include as a part of the expense of executing the trust the lawful premium paid a surety corporation for executing such obligation. Any party entitled

to recover costs or disbursements in an action or special proceeding may include in such disbursements the lawful premium paid to such corporation for a suretyship obligation. Any public officer, required by law to give a suretyship obligation, may pay the lawful premium for the execution of such obligation out of any moneys available for the payment of expenses of his office or department, unless such payment is otherwise provided for or is prohibited by law.

See note to 271.04, citing Skelly Oil Co. v. Peterson, 257 W 300, 43 NW (2d) 449.

See note to 271.04, citing Confidential Loan & Mortgage Co. v. Hargrove, 259 W 346, 48 NW (2d) 466.

204.12 Surety company reserves. (1) Every surety corporation shall at all times keep and maintain: (a) An unearned premium reserve of fifty per cent of the current annual premiums upon all outstanding suretyship obligations; provided, that the commissioner, in estimating its condition, may charge it with a premium reserve equal to the unearned portions of the gross premiums charged, computed on each risk, from the date of the issuance of such suretyship obligation; and (b) a loss reserve at least equal to the aggregate estimated amount of all losses and claims of which the corporation has received notice, and the estimated liability on any known event which may result in a loss, and the estimated liability for all losses which have occurred but on which no notice has been received.

(3) Whenever, in the judgment of the commissioner, the loss reserves on the suretyship obligations of any corporation, calculated in accordance with this section, are inadequate he may require such corporation to maintain additional reserves.

History: 1951 c. 33.

204.14 Estoppel. Any corporation which shall execute any bond, recognizance, obligation, stipulation or undertaking as surety shall be estopped, in any proceeding to enforce the liability which it shall have assumed to incur, to deny its power to execute the same or assume such liability.

204.22 Credit guarantee company. Any corporation licensed to do a credit guarantee business in this state may agree to pay to persons engaged in business and giving credit in the same, the debts owing to them, and indemnify them from credit losses, and may charge any consideration for such contract of indemnity which shall be agreed upon, buy and take an assignment of any claims, accounts and demands so guaranteed and enforce the collection thereof the same as the original owner could do; and may insure the payment of compensation for personal services under contracts of hiring. Any such corporation may use its capital or other funds to purchase any claim or demand the payment of which it has guaranteed.

204.23 Employer's liability policy. No casualty corporation issuing employer's liability policies shall condition the same upon compliance by the assured with "any law or ordinance respecting the safety of persons," but shall clearly and distinctly state what conditions and requirements are to be complied with by him.

204.24 Casualty and surety companies, dividends, reduction of capital, surplus. Domestic casualty and surety corporations shall declare dividends only out of their net surplus; and dividends in any fiscal year shall not exceed ten per cent of the capital unless and until the net surplus remaining thereafter shall equal fifty per cent of the capital stock. In estimating the net surplus there shall be deducted a sum equal to the unearned premiums; all sums due the corporation on bonds, mortgages, stocks and book accounts of which no part of the principal or the interest thereon had been paid during the last year, and for the collection of which no action has been commenced and on judgments more than two years old, and on which interest shall not have been paid; and all interest due to and all deposits for the special protection of policyholders of other states or of foreign countries. Any dividend made contrary to the provisions of this section shall be cause for the forfeiture of the charter of the corporation and each stockholder receiving such dividend shall be liable to its creditors to the extent of the dividend received. Any dividend declared or paid in violation of this section shall render the directors (except directors who were absent or whose dissent was entered in the minutes of the meeting which authorized the act) jointly and severally liable to the corporation and its creditors to the full amount paid out.

204.25 Casualty and surety companies' stock dividend. Any domestic casualty insurance or surety corporation which shall have a surplus fund, in addition to the amount of its capital stock and all liabilities, including reinsurance reserve in excess of one-half of the amount of all premiums on outstanding risks, may increase its capital stock from such fund and distribute the shares pro rata to its stockholders; provided, that such in-

crease shall be equal to at least twenty-five per cent of the original capital stock and shall have been authorized by at least three-fourths of the directors and approved by the commissioner.

204.26 Impairment of capital, how made good. (1) If in the opinion of the commissioner the reduction of capital authorized by section 200.06 will not be to the interest of the policyholders, or in the event of the refusal of the stockholders to consent thereto, he shall determine the amount of the impairment of the capital of the corporation and issue a requisition to the corporation to restore the capital within such period as he may designate, not less than thirty nor more than ninety days from the service of the requisition. Upon receipt of such requisition the directors shall forthwith call upon the stockholders ratably for such amounts as will make up such impairment.

(2) If any stockholder refuse or neglect to pay the amount called for after notice, given personally or by advertisement, in the time limited by the order of the commissioner, the directors may, by resolution, declare the stock of such person canceled; but such failure to pay shall not release the stockholder from any liability. The directors may issue new certificates of stock in lieu of the stock forfeited and dispose of the same at not less than par.

(3) For any losses accruing upon risks taken after the expiration of the period limited by the commissioner in such order and before such impairment shall be made up, the director shall be jointly and severally liable; and any transfer of stock, made during the pendency of any examination by the commissioner or after any such order shall have been made and before any impairment specified therein shall be made good, shall not release the transferor from his liability for loss accruing previous thereto.

(4) Every domestic corporation and every foreign corporation which shall purchase, own or in any manner control the voting of any stock in a domestic life, fire or casualty insurance company shall be liable for any assessment made against the stockholders of such insurance company as determined by the commissioner of insurance in the same manner as is provided for individual stockholders. In case the assessment against such corporation made as provided herein shall not be fully paid by such corporation, then the stockholders of such corporation shall be liable for an assessment sufficient to cover the full amount of the assessment against such corporation.

204.28 Employers' liability reserves, computation, allocation, definitions. (1) The reserve for outstanding losses under insurance against loss or damage from accident or injuries to any person and for which the insured is liable shall be computed as follows as of the date of computation:

(a) For all liability suits being defended under policies written more than ten years prior to that date, one thousand five hundred dollars for each suit; and for more than five and less than ten years prior thereto, one thousand dollars for each suit; and for more than three and less than five years prior thereto, eight hundred and fifty dollars for each suit.

(b) For all liability policies written during the three years immediately preceding such date, such reserve shall be sixty per centum of the earned liability premiums of each of such three years less all loss and loss expense payments made under liability policies written in said years; but in any event, such reserve shall, for the first of such three years, be not less than seven hundred and fifty dollars for each pending suit on said year's policies.

(c) For all compensation claims under policies written more than three years prior to such date, the present values at four per centum interest of the determined and the estimated future payments.

(d) For all compensation claims under policies written in the three years immediately preceding said date, such reserve shall be sixty-five per centum of the earned premiums of each of such three years, less all loss and loss expense payments made in connection with such claims under policies written in the corresponding years; but in any event, for the first year of such three-year period such reserve shall be not less than the present value at four per centum interest of the determined and the estimated claims under policies written during such year.

(2) (a) As used in this section, the term "earned premiums" shall include gross premiums charged on all policies, including all determined excess and additional premiums, less return premiums other than premiums returned to policyholders as dividends and less reinsurance premiums and premiums on policies canceled and less unearned premiums on policies in force. But any participating company which has charged in its premium a loading in excess of its average expense requirements shall not be required to include such loading in its earned premiums; provided, the amount of such loading is approved by the commissioner.

(b) The term "compensation" relates to all insurance providing compensation to employes for personal injuries, irrespective of fault of the employer. The term "liability" relates to all insurance except compensation insurance against loss or damage from accident to or injuries suffered by an employe or other person and for which the insured is liable.

(c) The terms "loss payment" and "loss expense payments" include all payments to claimants, payments for medical and surgical attendance, legal expenses, salaries and expenses of investigators, adjusters and fieldmen, rents, stationery, telegraph and telephone charges, postage, salaries and expenses of office employes, home office expenses, and all other payments made on account of claims, whether such payments shall be allocated to specific claims or unallocated.

(3) All unallocated liability loss expense payments made in a given calendar year subsequent to the first four years in which an insurer has been issuing liability policies shall be distributed as follows: Thirty-five per centum shall be charged to the policies written in that year; forty per centum to the policies written in the preceding year; ten per centum to the policies written in the second year preceding; ten per centum to the policies written in the third year preceding; and five per centum to the policies written in the fourth year preceding, and such payments made in each of the first four calendar years in which an insurer issues liability policies shall be distributed as follows: In the first calendar year one hundred per centum shall be charged to the policies written in that year, in the second calendar year fifty per centum shall be charged to the policies written in that year and fifty per centum to the policies written in the preceding year, in the third calendar year forty per centum shall be charged to the policies written in that year, forty per centum to the policies written in the preceding year, and twenty per centum to the policies written in the second year preceding, and in the fourth calendar year thirty-five per centum shall be charged to the policies written in that year, forty per centum to the policies written in the preceding year, fifteen per centum to the policies written in the second year preceding, and ten per centum to the policies written in the third year preceding, and a schedule showing such distribution shall be included in the annual statement.

(3a) All unallocated compensation loss expense payments made in a given calendar year subsequent to the first three years in which an insurer has been issuing compensation policies shall be distributed as follows: Forty per centum shall be charged to the policies written in that year, forty-five per centum to the policies written in the preceding year, ten per centum to the policies written in the second year preceding and five per centum to the policies written in the third year preceding, and such payments made in each of the first three calendar years in which an insurer issues compensation policies shall be distributed as follows: In the first calendar year one hundred per centum shall be charged to the policies written in that year, in the second calendar year fifty per centum shall be charged to the policies written in that year and fifty per centum to the policies written in the preceding year, in the third calendar year forty-five per centum shall be charged to the policies written in that year, forty-five per centum to the policies written in the preceding year, and ten per centum to the policies written in the second year preceding and a schedule showing such distribution shall be included in the annual statement.

(4) Whenever in the judgment of the commissioner the liability or compensation loss reserves of any insurer, calculated in accordance with the foregoing provisions, are either inadequate or excessive, he may, in his discretion require or permit such insurer to set up reserves based upon estimated individual claims or such other basis as he may approve.

(5) Each insurer that writes liability or compensation policies shall include in the annual statement required by law a schedule of its experience thereunder in such form as the commissioner may prescribe.

204.29 Notice of injury; service. (1) No licensed accident or casualty insurance company in Wisconsin shall limit the time for the service of any notice of injury to less than twenty days, except as provided in section 204.31.

(3) The deposit in any post office by or for the insured of a registered, postage prepaid envelope, containing the proper notice of injury within twenty days after the injury addressed to the company, issuing the policy or certificate, shall be a sufficient service of notice of injury.

History: 1951 c. 614.

Under an automobile liability policy providing that notice of accident shall be "given" as soon as practicable, but carrying on the face of the policy in large letters a direction to "send" all notices of accident to the insurer's Madison address without prescribing the manner of sending, and in view of the rule that provisions which tend to limit the liability of the insurer or which are ambiguous should be construed most strongly against the insurer, and in view of (3), it is not necessary that the notice actually be received by the insurer, but it is sufficient if the notice is sent as directed on the face of the policy, in the ordinary mail and within the time limited by the policy or the statute. Heimbecher v. Johnson, 258 W 200, 45 NW (2d) 610.

204.30 Accident insurance, highway traffic, policy provisions. (1) No policy of insurance against loss or damage resulting from accident or injury to a person, and for which the insured is liable, or against loss or damage to property caused by animals or by any motor vehicle, and for which the insured is liable, shall be issued or delivered in this state unless it shall contain a provision that the insolvency or bankruptcy of the insured shall not release the insurer from the payment of damages for injury sustained or loss occasioned, and that in case execution, in an action brought upon the policy against the insured, is returned unsatisfied, then an action may be maintained against such insurer for the amount due on the judgment not exceeding the amount of the policy.

(2) No such policy shall be issued or delivered in this state on or after September 1, 1925, by any company, unless there shall be contained within such policy a provision that notice given by or on behalf of the insured to any authorized agent of the insurer within this state, with particulars sufficient to identify the insured, shall be deemed to be notice to the insurer, and also a provision that failure to give any notice required to be given by such policy within the time specified therein shall not invalidate any claim made by the insured if it shall be shown not to have been reasonably possible to give such notice within the prescribed time and that notice was given as soon as reasonably possible.

(3) No such policy shall be issued or delivered in this state to the owner of a motor vehicle, unless it contains a provision reading substantially as follows: The indemnity provided by this policy is extended to apply, in the same manner and under the same provisions as it is applicable to the named assured, to any person or persons while riding in or operating any automobile described in this policy when such automobile is being used for purposes and in the manner described in said policy. Such indemnity shall also extend to any person legally responsible for the operation of such automobile. The insurance hereby afforded shall not apply unless the riding, use or operation above referred to be with the permission of the assured named in this policy, or if such assured is an individual, with the permission of an adult member of such assured's household other than a chauffeur or domestic servant, such permission in both cases to be deemed permission without regard to s. 85.08 (39) or to whether the riding, use or operation is authorized by law; but no insurance afforded by this paragraph shall apply to a public automobile garage or an automobile repair shop, sales agency, service station and the agents or employes thereof. In the event an automobile covered by this policy is sold or transferred the purchaser or transferee shall not be an additional insured without consent of the company, endorsed hereon.

History: 1955 c. 349.

Under an automobile liability policy defining "insured" as including the named insured, and any person while using the car, and any person or organization legally responsible for the use thereof, and excluding from the coverage bodily injury to or death of any employe of the insured while engaged in the employment of the insured or in the operation of the car, and the omnibus coverage of (3) incorporated in the policy by law, the indemnity which the named insured has is extended to apply in the same manner and under the same provisions as it is applicable to the named insured to those who operate the car with the named insured's consent, and also to those who are legally responsible for its operation, provided such operation is with the consent of the named insured, so that the named insured has no insurance protection if the claim is by his own employe but is protected against the claims of all others, and likewise an additional insured has no protection when the claim is by his employe but is protected against the claims of persons not so related to him, no matter who else may be the employer of the claimant. Accordingly, under such a policy, the named insured had insurance protection where he was driving the car at the time of an accident and his companion, injured in the accident, was not his employe, although the named insured and his companion, the claimant, were employes of a common employer and were in the course of their employment. (Brandt v. Employers' Liability Assur. Corp. 228 W 328, overruled.) Sandstrom v. Estate of Clausen, 258 W 534, 46 NW (2d) 831.

Under an automobile policy defining "insured" as including the named insured, and any person while using the car with the permission of the named insured, and any person or organization legally responsible for the use thereof, and the omnibus coverage of (3), incorporated in the policy by law—an exclusion clause excluding from the coverage bodily injury to or death of any employe of the insured while engaged in the employment of the insured or in the operation of the car, and excluding any obligation for which the insured might be held liable under the workmen's compensation law, did not exclude a person who was driving the car at the time of an accident and was an additional insured, from coverage for liability for the death of a person riding with him who was not his employe nor the employe of the named insured, but was the employe of a third person who sustained no tort liability and was not an additional insured in relation to this accident. Buck v. Home Mut. Casualty Co. 258 W 538, 46 NW (2d) 749.

Under an automobile liability policy covering a truck, defining "insured," as including the named insured and any person while using the vehicle with the permission of the named insured—an exclusion clause, excluding from the coverage bodily injury to or death of any employe of the insured while engaged in the employment of the insured or in the operation of the vehicle, did not exclude a person, who was an additional insured operating the truck on the farm of the named insured when it struck and injured a third person, from coverage for liability to such third person, where there was no employer-employe relationship between such operator-additional insured and such injured person. McMann v. Faulstich, 259 W 7, 47 NW (2d) 317.

Where an employe, while a passenger in his employer's truck driven by a coemploye, was injured in a collision with another vehicle, and the 2 employes were in the course of their employment at the time, the employe-driver of the truck was an additional insured within the statutory omnibus cov-

erage clause of the employer's automobile liability policy, so as to be entitled to the benefits of the policy, and the insurer was subject to liability for the injuries of the employe-occupant, although the policy contained an exclusion clause providing that its insurance coverage did not apply to "bodily injury to . . . any employe of the insured while engaged in the employment of the insured, or to any obligation for which the insured . . . may be held liable under any workmen's compensation law," and the insured-employer and his employes were subject to the workmen's compensation act. (Sandstrom v. Estate of Clausen, 258 W 534, applied.) Zippel v. Country Gardens, Inc. 262 W 567, 55 NW (2d) 903.

Under an automobile policy providing for a continuation of the coverage thereunder in case of the death of the named insured, for a period of not more than 60 days after the death, if notice of the death was given to the insurer within 60 days after the death, the insurer was not subject to liability as to a collision which occurred 94 days after the death of the named insured and without such notice having been given to the insurer, in the absence of conduct by the insurer creating an estoppel against asserting such defense of nonliability or amounting to a waiver of such defense. Whirry v. State Farm Mut. Automobile Ins. Co. 263 W 322, 57 NW (2d) 330.

See note to 102.29, citing Doyle v. Teasdale, 263 W 328, 57 NW (2d) 381.

See note to 85.09, citing Olander v. Klapprote, 263 W 463, 57 NW (2d) 734.

A provision in an automobile liability policy that the insured will reimburse the insurer for any loss suffered by the insurer arising out of the negligent operation of the car by a person under the age of 25 years, as applied to the operation of the car by a member of the insured's household under 25 but of an age authorized by law to drive a car, is void as violating 204.34 (1), providing that no such policy shall exclude from its coverage persons driving a motor vehicle who are of an age authorized by law so to do, and 204.30 (3), prescribing the extended coverage which such a policy shall provide. Olander v. Klapprote, 263 W 463, 57 NW (2d) 734.

Under an automobile liability and collision policy providing that the policy might be canceled by the insurer by mailing to the named insured's address a written notice stating when, not less than 5 days thereafter, such cancellation should be effective, and that the mailing of such notice should be sufficient proof of notice, and that the effective date of cancellation stated in the notice should become the end of the policy period, proof of the mailing of such notice, properly addressed, was sufficient to accomplish a cancellation on the date specified in the notice, even though the notice may not have been received by the insured. Wisconsin Nat. Gas. Co. v. Employers Mut. L. Ins. Co. 263 W 633, 58 NW (2d) 424.

As used in (3), the word "permission" means legal permission, so that an unlicensed 15-year-old driver to whom the named insured, as owner, was prohibited by 85.08 (39) from granting permission to operate the vehicle, was not an additional insured so as to be afforded the protection of the policy, although he was driving it with the actual permission of the named insured. Quin v. Hoffmann, 265 W 636, 62 NW (2d) 423.

A general exclusion clause, providing that the policy does not apply "to any employe with respect to injury to . . . or death of another employe of the same employer injured in the course of such employment in an accident arising out of the maintenance or use of the automobile in the business of such employer," operated to exclude an employe of the named insured from coverage as an additional insured in a situation where such employe was operating the insured truck with permission and backed it into a fellow employe, and both employes were performing service for their common employer at the time of the accident; such exclusion clause being plain and unambiguous, and not being repugnant to (3) nor violative of public policy. (Buck v. Home Mut. Casualty Co. 258 W 538, and other cases distinguished.) Schneider v. Depies, 266 W 43, 62 NW (2d) 431.

A named insured cannot recover from his insurer for injuries sustained while a guest in his own car, where the policy contains a general exclusion clause against such coverage. (Frye v. Theige, 253 W 596, followed; Sandstrom v. Estate of Clausen, 258 W 534 and McMann v. Faulstich, 259 W 7, distinguished.) Musselman v. Mutual Automobile Ins. Co. 266 W 387, 63 NW (2d) 691.

Policy provision that "insured" includes "not only the named insured but also any person while using the automobile" provided "the actual use is with the permission of the named insured" is broader than that required by (3). Here named insured (father) knew his son was using the car and that a classmate often drove. Under these circumstances there was a consent to the use and an implied consent to the operation by the classmate. Schimke v. Mut. Automobile Ins. Co. 266 W 517, 64 NW (2d) 195.

A provision in the omnibus coverage clause, providing that the insurance with respect to any person "other than the named insured" does not apply to any employe with respect to injury to another employe of the same employer injured in the course of such employment in an accident arising out of the maintenance or use of the automobile in the business of such employer, is void as being repugnant to (3) in providing for an exception applicable solely to an additional insured, whereas (3) requires that an omnibus coverage clause afford coverage to an additional insured to the same extent as is afforded to the named insured. (Schneider v. Depies, 266 W 43, distinguished.) Shanahan v. Midland Coach Lines, 268 W 233, 67 NW (2d) 297.

A general exclusion clause, providing that the policy does not apply to bodily injury to any employe of the insured while engaged in the employment of the insured, does not operate to exclude additional insureds where such additional insureds were not employers of the injured employe. (3) is not meant to give additional insureds greater coverage than that given the named insured; but if a policy does in fact grant to additional insureds more protection than is afforded to the named insured, it is a matter of contract and is not inconsistent with the provisions of such statute. Shanahan v. Midland Coach Lines, 268 W 233, 67 NW (2d) 297.

204.31 Accident and sickness insurance policy. (1) DEFINITION. "Policy of accident and sickness insurance" as used in this section includes any policy or contract covering the kind or kinds of insurance described in section 201.04 (4).

(2) FORM OF POLICY. (a) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

1. The entire money and other considerations therefor are expressed therein;

2. The time at which the insurance takes effect and terminates is expressed therein;

3. It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any 2 or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 19 years and any other person dependent upon the policyholder;

4. The style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than 10-point with a lower-case unspaced alphabet length not less than 120-point (the "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions);

5. The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in subsection (3), are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provisions to which it applies;

6. Each such form, including riders and endorsements, is identified by a form number in the lower left-hand corner of the first page thereof;

7. It contains no provision purporting to make any portion of the charter, rules, constitution, or by-laws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state has advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in paragraph (a) and in subsection (3).

(3) ACCIDENT AND SICKNESS POLICY PROVISIONS. (a) *Required provisions.* Except as provided in paragraph (c) each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear; provided, however, that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption to such provision appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

1. Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

2. Time Limit On Certain Defenses: a. After 3 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 3-year period. (The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial 3-year period, nor to limit the application of subsection (3) (b) 1, 2, 3, 4 and 5 in the event of misstatement with respect to age or occupation or other insurance.)

am. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least 5 years from its date of issue, may contain in lieu of the provisions in sub. (3) (a) 2. a. the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONSTESTABLE": After this policy has been in force for a period of 3 years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

b. No claim for loss incurred or disability (as defined in the policy) commencing after 3 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

3. Grace Period. a. A grace period of .... (insert a number not less than 7 for weekly premium policies, 10 for monthly premium policies and 31 for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

b. A policy which contains a cancellation provision may add, at the end of the above provision: subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

c. A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision: unless not less than 5 days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.

4. Reinstatement: a. If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

b. The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or, in the case of a policy issued after age 44, for at least 5 years from its date of issue.

5. Notice Of Claim: a. Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at .... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

b. In a policy providing a loss-of-time benefit which may be payable for at least 2 years, an insurer may at its option insert the following between the first and second sentences of the above provision: subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least 2 years, he shall, at least once in every 6 months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of 6 months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of 6 months preceding the date on which such notice is actually given.

6. Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

7. Proofs Of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

8. Time Of Payment Of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid .... (insert period for payment which must not be less frequently than monthly)

and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

9. Payment Of Claims: a. Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

b. The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $.... (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

10. Physical Examinations And Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

11. Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

12. Change Of Beneficiary: a. Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

b. The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

(b) *Other Provisions.* Except as provided in paragraph (c), no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this paragraph; provided, however, that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

1. Change Of Occupation: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro-rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

2. Misstatement Of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

3. Other Insurance In This Insurer: a. If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for .... (insert type of coverage or coverages) in excess of $.... (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

b. In lieu of the provisions in subsection (3) (b) 3. a. the following may be used: insurance effective at any time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

4. Insurance With Other Insurers: a. If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

b. If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "— EXPENSE INCURRED BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employe benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".

5. Insurance With Other Insurers: a. If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense insured basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

b. If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase "—OTHER BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employe benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer

has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".

6. Relation Of Earnings To Insurance: a. If the total monthly amount of loss-of-time benefits promised for the same loss under all valid loss-of-time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such 2 years as shall exceed the pro-rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefit specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

b. The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or, in the case of a policy issued after age 44, for at least 5 years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss-of-time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employe benefit organizations.

7. Unpaid Premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

8. Cancellation: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than 5 days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro-rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

9. Conformity With State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

10. Illegal Occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

11. Intoxicants And Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(c) *Inapplicable or inconsistent provisions.* If any provision of this subsection is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(d) *Order of certain policy provisions.* The provisions which are subject to paragraphs (a) and (b), or any corresponding provisions which are used in lieu thereof under this subsection, shall be printed in the consecutive order of the provisions in this subsection or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(e) *Third party ownership.* The word "insured", as used in this section, shall not be construed as preventing a person other than the insured with a proper insurable interest from making an application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

(f) *Requirements of other jurisdictions.* 1. Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this section and which is prescribed or required by the law of the state under which the insurer is organized.

2. Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the law of such other state or country.

(g) *Filing procedure.* 1. The commissioner may make such reasonable rules concerning the procedure for the filing or submission of policies subject to this section as are necessary, proper or advisable to the administration of this section. This provision shall not abridge any other authority granted the commissioner by law.

2. No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith until the expiration of 30 days after it has been so filed unless the commissioner shall sooner give his written approval thereto.

3. The commissioner may within 30 days after the filing of any such form disapprove such form if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains a provision which is unjust, unfair, inequitable, misleading, deceptive or encourages misrepresentation of such policy. If the commissioner notifies the insurer that the form does not comply with this subsection, it is unlawful thereafter for such insurer to issue or use such form. In such notice the commissioner shall specify the reason for his disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer.

4. The commissioner may at any time, after a hearing on not less than 20 days' written notice to the insurer, withdraw his approval of any such form on any of such grounds. It is unlawful for the insurer to issue such form or use it after the effective date of such withdrawal of approval.

5. Notice of all hearings shall specify the matters to be considered, and each decision affirming disapproval or directing withdrawal of approval shall be in writing and shall specify the reasons.

(h) *Other policy provisions.* No policy provision which is not subject to subsection (3) shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this section.

(i) *Conflicting policy.* A policy delivered or issued for delivery to any person in this state in violation of this section shall be held valid but shall be construed as provided in this section. When any provision in a policy subject to this section is in conflict with any provision of this section, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this section.

(4) APPLICATION. (a) The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within 15 days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

(b) No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(c) The falsity of any statement in the application for any policy covered by this section may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

(5) NOTICE, WAIVER. The acknowledgment by any insurer of the receipt of notice given under any policy covered by this section, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

(6) AGE LIMIT. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

(7) NONAPPLICATION TO CERTAIN POLICIES. Nothing in this section shall apply to or affect (a) any policy of workmen's compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein; or (b) any policy or contract of reinsurance; or (c) any blanket or group policy of insurance; or (d) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as provide additional benefits in case of death or dismemberment or loss of sight by accident, or operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

(8) VIOLATION. Any person, wilfully violating any provision of this section or order of the commissioner made in accordance with this section, shall forfeit a sum not to exceed $100 for each such violation, which may be recovered by a civil action. The commissioner may also suspend or revoke the license of an insurer or agent for any such wilful violation.

(9) JUDICIAL REVIEW. Any order or decision of the commissioner under this section shall be subject to judicial review in the manner provided in chapter 227.

(10) EFFECTIVE DATE. A policy, rider or endorsement, which could have been lawfully used or delivered or issued for delivery to any person in this state immediately before January 1, 1952 may be used or delivered or issued for delivery to any such person during 5 years after said date without being subject to the provisions of section 204.31.

History: 1951 c. 614; 1953 c. 61.

204.32 Franchise, group and blanket accident and health insurance. (1) Franchise accident and health insurance is declared to be that form of accident and health insurance covering 3 or more employes or members of any governmental corporation, unit, agency or department thereof, or of any corporation, copartnership or individual employer, or of any association, including a labor union, having a constitution or bylaws, and formed in good faith for purposes other than that of obtaining insurance, where such employes, members or employes of members with or without their dependents are covered under individual policies of insurance, under an arrangement whereby the premium on such policies are to be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association, as the case may be, or by some designated person acting on behalf of such employer or association or of such employes or members. Any insurance company authorized to write accident and health insurance in this state shall have power to issue franchise accident and health policies. The term "employes" as used herein shall be deemed to include the officers, managers and employes of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership. Notwithstanding any provision contained in the statutes of this state, insurers may be permitted to file, for use in connection with franchise health and accident insurance, rate schedules which reflect a differential from the rates charged for identical policies issued on the individual basis, provided the rates charged under such rate schedules do not discriminate between franchise groups.

(2) (a) Group accident and health insurance is hereby declared to be that form of accident and health insurance covering groups of persons as defined below, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups of persons, and issued under a policy issued to:

1. An employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring at least 10 employes of such employer for the benefit of persons other than the employer. The term "employes" as used herein shall be deemed to include the officers, managers and employes of the employer, the individual proprietor or partner if the employer is an individual proprietor or partnership, the officers, managers and employes of subsidiary or affiliated corporations, the individual proprietors, partners and employes of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract or otherwise. The term "employes" as used herein may include retired employes. A policy issued to insure em-

ployes of a public body may provide that the term "employes" shall include elected or appointed officials; or

2. An association, including a labor union, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring at least 25 members, employes, or employes of members of the association for the benefit of persons other than the association or its officers or trustees. The term "employes" as used herein may include retired employes; or

3. The trustees of a fund established by 2 or more employers in the same industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as defined in subd. 2, which trustees shall be deemed the policyholder, to insure employes of the employers or members of the unions or such association for the benefit of persons other than the employers or the unions or such association. The term "employes" as used herein may include the officers, managers and employes of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The term "employes" as used herein may include retired employes. The policy may provide that the term "employes" shall include the trustees or their employes, or both, if their duties are principally connected with such trusteeship; or

4. Any person or organization to which a policy of group life insurance may be issued or delivered under s. 206.60 (2), (5) or (6), to insure any class or classes of individuals that could be insured under such group life policy; or

5. Cover any other substantially similar group which, in the discretion of the commissioner, may be subject to the issuance of a group accident and health policy or contract.

(b) Each such policy shall contain in substance the provisions that:

1. In the absence of fraud, all statements made by any applicant or applicants or the policyholder or by an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary; and

2. The insurer will furnish to the policyholder for delivery to each employe or member of the insured group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of such employe or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit; and

3. To the group originally insured may be added from time to time eligible new employes or members or dependents, as the case may be, in accordance with the terms of the policy.

(c) Any group accident and health policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

(d) No policy of group accident and health insurance shall be issued unless it contains in substance those provisions contained in s. 204.31 which may be applicable to group accident and health insurance relative to notice or proof of loss, or the time for paying benefits, or the time within which suit may be brought upon the policy.

(3) (a) Blanket accident and health insurance is hereby declared to be that form of accident and health insurance covering groups of persons under a policy or contract issued:

1. To any common carrier or to any operator, owner or lessee of a means of transportation, who or which shall be deemed the policyholder covering a group defined as all persons or all persons of a class who may become passengers on such common carrier or such means of transportation; or

2. To an employer, who shall be deemed the policyholder, covering all employes, dependents or guests, defined by reference to specified hazards incident to the activities or operations of the employer or any class of employes, dependents or guests similarly defined; or

3. To a school, or other institution of learning, camp or sponsor thereof, or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or campers. Supervisors and employes may be included; or

4. In the name of any religious, charitable, recreational, educational, or civic organization, which shall be deemed the policyholder, covering participants in activities sponsored by the organization; or

5. To a sports team or sponsors thereof which shall be deemed the policyholder, covering members, officials and supervisors; or

6. To cover any other risk or class of risks which, in the discretion of the commissioner, may be properly eligible for blanket accident and health insurance. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both.

(b) No policy of blanket accident and health insurance shall be issued unless it contains in substance those provisions contained in s. 204.31 which may be applicable to such insurance relative to notice of claim, claim forms, proofs of loss, time of payment of claims, physical examinations and legal actions.

(c) Each blanket accident and health insurance policy issued in this state shall contain a provision that the policy and the application shall constitute the entire contract between the parties, and that all statements made by the policyholder shall, in absence of fraud, be deemed representations and not warranties, and that no such statements shall be used in defense to a claim under the policy, unless it is contained in a written application.

(d) An individual application shall not be required from a person covered under a blanket accident and health policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

(e) All benefits under any blanket accident and health policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, except: that if the person insured be a minor or mental incompetent, such benefits may be made payable to his parent, guardian, or other person actually supporting him; or if the entire cost of the insurance has been borne by the employer such benefits may be made payable to the employer. Provided further that the policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

(4) No policy authorized in this section may be issued or delivered in this state until a copy of the form thereof shall have been filed with the commissioner, nor until 30 days thereafter unless he approves the form sooner. If he notifies the company that the form does not comply with the requirements of law, specifying the defect, it is unlawful to issue any policy in such form. No such policy shall be issued or delivered in this state unless a schedule of the premium rates pertaining to such form also has been filed with the commissioner.

History: 1951 c. 614; 1955 c. 461.

Under (2) (b), requiring that the application for the policy constitute the contract, and that the insurer issue a certificate to the individual group members, a certificate so issued which states coverage and conditions differing from those of the policy estops the insurer from asserting the policy provisions. Riske v. National Casualty Co. 268 W 199, 67 NW (2d) 385.

204.33 Direct payment. Any policy providing disability insurance which includes benefits payable on account of hospital, medical or surgical services rendered to or for an insured, including an employe or other member of any group insured by such policy, his or her spouse, child or children, or other dependents, may also provide that any such benefits be paid by the insurer directly to the hospital, physician, or other institution or person furnishing services covered by such provisions of the policy. The last paragraph in section 204.31 (3) (a) 9. b. shall not apply to any policy written in accordance with section 204.31 and which provides for direct payment as permitted in this section.

History: 1951 c. 614.

204.34 Provisions of auto liability policies. (1) No policy of insurance, agreement of indemnity or bond covering liability or loss arising by reason of the ownership, maintenance or use of a motor vehicle issued in this state shall exclude from the coverage afforded or provisions as to benefits therein any of the following:

(a) Persons while driving or manipulating a motor vehicle, who shall be of an age authorized by law so to do;

(b) The operation, manipulation or use of such motor vehicle for unlawful purposes;

(c) The operation, manipulation or use of such motor vehicle while the driver is under the influence of intoxicating liquors or narcotics; while such motor vehicle is engaged in the transportation of liquor in violation of law, or while such motor vehicle is operated in a reckless manner.

(2) No policy of insurance, agreement of indemnity or bond referred to in subsection (1) shall exclude from the coverage afforded or the provisions as to the benefits therein provided persons related by blood or marriage to the assured.

(3) No policy of insurance, agreement of indemnity or bond as provided in subsection (1) shall limit the time for the giving of notice of any accident or casualty covered thereby to a period less than that provided in subsection (1) of section 204.29. Failure to give such notice shall not bar liability under such policy of insurance, agreement of in-

demnity or bond as provided in subsection (1) if the insurer was not prejudiced or damaged by such failure, but the burden of proof to so show shall be upon the person claiming such liability.

The provision in (3), that failure to give notice of accident to the insurer shall not bar liability under a policy if the insurer was not prejudiced by such failure, cannot be extended to apply to a failure to comply with a policy condition requiring the insured immediately to forward to the insurer every demand, notice, summons or other process received by the insured, particularly where notice of suit was not given to the insurer until 17 months after the accident. Heimlich v. Kees Appliance Co. 256 W 356, 41 NW (2d) 359.

(3) creates a presumption that an automobile liability insurer is prejudiced by a failure to give timely notice of accident and puts the burden of proof to rebut the presumption on the person claiming liability. In an action by a person injured as the result of the negligent operation of an automobile, against the operator's liability insurer alone, the record fact that no notice, under a policy requiring notice of accident to the insurer "as soon as practicable," was given to the insurer until 11 months after the accident, required a determination that as a matter of law the notice was not given as soon as practicable, and, in the absence of any proof offered to establish to the contrary, that the insurer was prejudiced by the delay; requiring dismissal of the complaint. Calhoun v. Western Casualty & Surety Co. 260 W 34, 49 NW (2d) 911.

In an action by the injured person against the automobile liability insurer alone, the insurer, with no alternative except to defend or to permit judgment to be taken against it by default, did not waive and was not estopped to assert the defense of untimeliness of a notice of accident given 11 months after the accident, and to disclaim liability under the policy on that ground, by reason of the fact that the insurer's subsequent investigation of the accident had disclosed full information that the insured had given a signed statement of the facts and talked to the insurer's representative, and was in court as a witness, and that the insurer had made no prior disclaimer of liability. Calhoun v. Western Casualty & Surety Co. 260 W 34, 49 NW (2d) 911.

See note to 204.30, citing Olander v. Klapprote, 263 W 463, 57 NW (2d) 734.

On a motion of a defendant liability insurer for summary judgment as to it, based on a policy provision requiring written notice by or on behalf of the insured as soon as practicable after an accident, and on an affidavit alleging that this accident occurred in 1948 but that no report was received at the office of the insurer until 1950, to the prejudice of the insurer, the plaintiffs' counteraffidavit, denying any knowledge or information as to when the insured made a report to the insurer, or whether it was a timely notice, was a sufficient denial so that summary judgment should not have been granted, lapse of time in giving the notice not being prejudicial as a matter of law under (3). Vlasis v. Cheese Makers Mut. Casualty Co. 268 W 389, 68 NW (2d) 23.

204.35 Limitation on risk. (3) No casualty or accident insurance company or mutual benefit society shall assume a greater risk on any one person payable in case of death of the assured than one-tenth of its assets reported to the commissioner and in existence at the time of the last annual report.

History: 1951 c. 33.

204.36 Auto insurance on autos purchased on finance plan. Any insurance company or its agent writing a policy of insurance for the benefit of the seller, finance company, or any person retaining an interest in any automobile purchased on a finance plan, or on a conditional sales contract or under any other plan which requires the purchaser of such automobile to maintain insurance, whether premiums for such insurance are paid directly to the insurance company by such purchaser or deducted from the payments made under such contract or plan or howsoever such premiums are paid, shall deliver to such purchaser a substantial copy of each and every policy written; and if any such policy is cancelled before the purchaser has fully paid for such automobile and is rewritten in the same insurance company or an affiliate thereof or any other insurance company because the original finance or purchasing plan is altered or a new plan or agreement of payment entered into, the unearned premium of any such policy shall be returned to or applied to the credit of the purchaser on a pro rata basis. Any insurance company or individual violating this section shall, for any offense, forfeit $500.

204.37 Insurance rates and practices; regulation; purpose of sections. The purpose of sections 204.37 to 204.54 is to promote the public welfare by regulating insurance rates made by rating organizations and by insurers to the end that they shall not be excessive, inadequate or unfairly discriminatory, and to authorize and regulate co-operative action among insurers in rate making and in other matters within the scope of said sections. Nothing in said sections is intended (1) to prohibit or discourage reasonable competition, or (2) to prohibit, or encourage except to the extent necessary to accomplish the aforementioned purpose, uniformity in insurance rates, rating systems, rating plans or practices. Said sections shall be liberally interpreted to carry into effect the provisions of this section.

204.38 Scope of sections. (1) Sections 204.37 to 204.54 apply to the kinds of insurance authorized by section 201.04 (5), (6), (7), (8), (9), (10), (11), (13), (14), (15), (17) and (18) on risks or operations in this state, except:

(a) Reinsurance, other than joint reinsurance to the extent stated in section 204.47;

(b) Insurance against loss of or damage to aircraft or against liability, arising out of the ownership, maintenance or use of aircraft;

(c) Insurance covering any part of the liability of an employer exempted from insuring his liability for compensation as provided in section 102.28.

(2) "Insurer" as used in ss. 204.37 to 204.54 shall be deemed to include every company as defined in s. 201.01, every surety corporation or company within the provisions of s. 204.01, and every stock or mutual company, reciprocal, interinsurance exchange, and Lloyd's association, which is authorized under any provision of the laws of this state to transact any of the kinds of insurance to which ss. 204.37 to 204.54 apply.

(3) If any kind of insurance, subdivision or combination thereof, or type of coverage, subject to ss. 204.37 to 204.54 is also subject to regulation by another rate regulatory act of this state, an insurer to which both acts are otherwise applicable shall file with the commissioner of insurance, hereinafter referred to as commissioner, a designation as to which rate regulatory act shall be applicable to it with respect to such kind of insurance, subdivision or combination thereof, or type of coverage.

History: 1951 c. 269.

204.39 Rate making. (1) All rates shall be made in accordance with the following provisions:

(a) Due consideration shall be given to past and prospective loss experience within and outside this state, to catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies, to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, to past and prospective expenses both countrywide and those specially applicable to this state, and to all other relevant factors within and outside this state;

(b) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable;

(c) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses;

(d) Rates shall not be excessive, inadequate or unfairly discriminatory.

(2) Except to the extent necessary to meet the provisions of subsection (1) (d), uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

204.40 Rate filings. (1) Every insurer shall file with the commissioner every manual of classifications, rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use, including short rate tables. Every such filing shall state the proposed effective date thereof, and shall indicate the character and extent of the coverage contemplated. Such short rate tables shall specify the percentages of the premium to be charged or retained by the insurer, and shall cover all policies of insurance the term of which is less than the term prescribed for such insurance by the rate and rating schedules as filed by such insurer or by a rating bureau or organization in behalf of such insurer. When a filing is not accompanied by the information upon which the insurer supports such filing, and the commissioner does not have sufficient information to determine whether such filing meets the requirements of ss. 204.37 to 204.54, he shall require such insurer to furnish the information upon which it supports such filing, and in such event the waiting period as to a filing made by a rating organization shall commence as of the date such information is furnished. Such requirement to furnish information shall not extend the effective date as to a filing made by an insurer for a kind of insurance or subdivision thereof as to which such insurer is not a member of or a subscriber to a rating organization. The information furnished in support of a filing may include: (a) the experience or judgment of the insurer or rating organization making the filing, (b) its interpretation of any statistical data it relies upon, (c) the experience of other insurers or rating organizations, or (d) any other relevant factors. A filing and any supporting information shall be open to public inspection after the filing becomes effective. Rates for the insurance specified in s. 201.04 (8) may be segregated from charges for examination of titles to real and personal property or furnishing information relative thereto.

(2) An insurer may satisfy its obligation to make such filings by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings, and by authorizing the commissioner to accept such filings on its behalf. Nothing contained in sections 204.37 to 204.54 shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization.

(3) The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of sections 204.37 to 204.54.

(4) Subject to the exception specified in subsection (5), each filing shall be on file for a waiting period of 15 days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed 15 days if he gives written notice within such waiting period to the insurer or rating organization which made the filing that he needs such additional time for the consideration of such filing. Upon written application by such insurer or rating organization, the commissioner may authorize a filing which he has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing made by a rating organization shall be deemed to meet the requirements of sections 204.37 to 204.54 unless disapproved by the commissioner within the waiting period or any extension thereof. A filing made by an insurer for a kind of insurance or subdivision thereof as to which such insurer is not a member of or subscriber to a rating organization shall be deemed to meet the requirements of said sections unless disapproved by the commissioner after notice and hearing and findings made in accordance with the requirements of section 204.41 (1) (b).

(5) Any special filing with respect to a surety or guaranty bond required by law or by court or executive order or by order, rule or regulation of a public body, not covered by a previous filing, shall become effective when filed and shall be deemed to meet the requirements of sections 204.37 to 204.54 until such time as the commissioner reviews the filing and so long thereafter as the filing remains in effect.

(6) Under such rules and regulations as he shall adopt the commissioner may, by written order, suspend or modify the requirement of filing as to any kind of insurance, subdivision or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used. Such orders, rules and regulations shall be made known to insurers and rating organizations affected thereby. The commissioner may make such examination as he may deem advisable to ascertain whether any rates affected by such order meet the standards set forth in section 204.39 (1) (d).

(7) Upon the written application of the insured, stating his reasons therefor filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

(8) On and after January 1, 1948, no insurer shall make or issue a contract or policy except in accordance with filings which are in effect for said insurer as provided in sections 204.37 to 204.54 or in accordance with subsection (6) or (7).

History: 1955 c. 433.

204.41 Disapproval of filings. (1) (a) If within the waiting period or any extension thereof as provided in section 204.40 (4) the commissioner finds that a filing made by a rating organization does not meet the requirements of sections 204.37 to 204.54 he shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing specifying therein in what respect he finds such filing fails to meet the requirements of said sections and stating that such filing shall not become effective.

(b) The commissioner may, in the case of a filing by an insurer for a kind of insurance or subdivision thereof as to which such insurer is not a member of or subscriber to a rating organization, disapprove such filing during the waiting period or any extension thereof, only after notice and hearing in accordance with the requirements of subsection (3) and only by order specifying in what respects he finds that such filing fails to meet the requirements of ss. 204.37 to 204.54.

(2) If within 30 days after a special surety or guaranty filing subject to section 204.40 (5) has become effective the commissioner finds that such filing does not meet the requirements of sections 204.37 to 204.54 he shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing specifying therein in what respects he finds that such filing fails to meet the requirements of said sections and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Said disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in said notice.

(3) At any time subsequent to the applicable review period provided for in subsection (1) or (2), the commissioner may, as to any filing whether by a rating organization or by an insurer disapprove a filing on the ground that such filing does not meet the requirements of sections 204.37 to 204.54, but only after a hearing held upon not less than 10 days' written notice specifying the matters to be considered at such hearing to every insurer and rating organization which made such filing, and only by an order specifying in what respect he finds that such filing fails to meet the requirements of said sections, and stating when within a reasonable period thereafter such filing shall be deemed no longer effective. Copies of said order shall be sent to every such insurer and rating organ-

ization. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order.

(4) (a) Any person or organization aggrieved with respect to any filing which is in effect may make written application to the commissioner for a hearing thereon, provided, however, that the insurer or rating organization that made the filing shall not be authorized to proceed under this subsection. Such application shall specify the grounds to be relied upon by the applicant. If the commissioner shall find that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that such grounds otherwise justify holding such a hearing, he shall, within 30 days after receipt of such application, hold a hearing upon not less than 10 days' written notice to the applicant and to every insurer and rating organization which made such filing.

(b) If after such hearing the commissioner finds that the filing does not meet the requirements of sections 204.37 to 204.54, he shall issue an order specifying in what respects he finds that such filing fails to meet the requirements of said sections and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Copies of said order shall be sent to the applicant and to every such insurer and rating organization. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order.

(5) No manual of classifications, rules, rating plans, or any modifications of any of the foregoing which establish standards for measuring variations in hazards or expense provisions, or both, and which has been filed pursuant to the requirements of section 204.40 shall be disapproved if the rates thereby produced meet the requirements of sections 204.37 to 204.54.

204.42 Rating organizations. (1) A corporation, an unincorporated association, a partnership or an individual, whether located within or outside this state, may make application to the commissioner for license as a rating organization for such kinds of insurance or subdivisions thereof as are specified in its application and shall file therewith (a) a copy of its articles of agreement or association or its certificates of incorporation, and of its by-laws, rules and regulations governing the conduct of its business, (b) a list of its members and subscribers, (c) the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such rating organization may be served and (d) a statement of its qualifications as a rating organization. If the commissioner finds that the applicant is competent, trustworthy and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association or certificate of incorporation, and its by-laws, rules and regulations governing the conduct of its business conform to the requirements of law, he shall issue a license specifying the kinds of insurance or subdivisions thereof for which the applicant is authorized to act as a rating organization. Every such application shall be granted or denied in whole or in part by the commissioner within 60 days of the date of its filing with him. Licenses issued pursuant to this section shall remain in effect for 3 years unless sooner suspended or revoked by the commissioner. The fee for said license shall be $25. Licenses issued pursuant to this section may be suspended or revoked by the commissioner, after hearing upon notice, in the event the rating organization ceases to meet the requirements of this subsection. Every rating organization shall notify the commissioner promptly of every change in (a) its constitution, its articles of agreement or association or its certificate of incorporation, and its by-laws, rules and regulations governing the conduct of its business, (b) its list of members and subscribers and (c) the name and address of the resident of this state designated by it upon whom notices or orders of the commissioner or process affecting such rating organization may be served.

(2) Subject to rules and regulations which have been approved by the commissioner as reasonable, each rating organization shall permit any insurer not a member to be a subscriber to its rating services for any kind of insurance or subdivision thereof for which it is authorized to act as a rating organization. Notice of proposed changes in such rules and regulations shall be given to subscribers. Each rating organization shall furnish its rating services without discrimination to its members and subscribers. The reasonableness of any rule or regulation in its application to subscribers or the refusal of any rating organization to admit an insurer as a subscriber shall, at the request of any subscriber or any such insurer, be reviewed by the commissioner at a hearing held upon at least 10 days' written notice to such rating organization and to such subscriber or insurer. If the commissioner finds that such rule or regulation is unreasonable in its application to subscribers he shall order that such rule or regulation shall not be applicable to subscribers. If the rating organization fails to grant or reject an insurer's application for subscribership within 30 days after it was made, the insurer may request a review by the commissioner as if the application had been rejected. If the commis-

sioner finds that the insurer has been refused admittance to the rating organization as a subscriber without justification he shall order the rating organization to admit the insurer as a subscriber. If he finds that the action of the rating organization was justified he shall make an order affirming its action.

(3) No rating organization shall adopt any rule the effect of which would be to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

(4) Co-operation among rating organizations or among rating organizations and insurers in rate making or in other matters within the scope of sections 204.37 to 204.54 is hereby authorized, provided the filings resulting from such co-operation are subject to all the provisions of said sections which are applicable to filings generally. The commissioner may review such co-operative activities and practices and if after a hearing he finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of said sections, he may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of said sections and requiring the discontinuance of such activity or practice.

204.43 Deviations from rates. Every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by such organization except that any insurer may file with the commissioner and with the rating organization of which it is a member or to which it is a subscriber, a deviation from the rates or any underwriting rule filed by such rating organization. Any such deviation from a rate shall be by uniform percentage decrease or increase applied to the premiums produced by the rating system so filed for a kind of insurance, or for a class of insurance which is found by the commissioner to be a proper rating unit for the application of such uniform percentage decrease or increase, or for a subdivision of a kind of insurance (1) comprised of a group of manual classifications which is treated as a separate unit for rate making purposes, or (2) for which separate expense provisions are included in the filings of the rating organization. Any such deviation shall not be such as to result in a rate which is excessive, inadequate or unfairly discriminatory. Such deviation shall not take effect for a period of 15 days after filing which waiting period may be extended for an additional period of 15 days by the commissioner if he gives written notice to the insurer and rating organization in accordance with the provisions of section 204.40 (4). Co-operation among insurers in the preparation, filing and use of deviations is hereby authorized. The commissioner may review such co-operative activities and practices and if, after hearing, held after notice to the insurer and rating organization involved in accordance with section 204.41 (3), he finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of sections 204.37 to 204.54, he may issue a written order specifying in what respects he finds that such filing fails to meet the requirements of said sections and requiring the discontinuance of such activity or practice within such reasonable period thereafter as shall be fixed by said order. Any such deviation shall be subject to disapproval by the commissioner if after notice to said insurer and rating organization and hearing in accordance with the provisions of section 204.41 (3) the commissioner shall find that such deviation does not meet the requirements of sections 204.37 to 204.54. Any such order of disapproval shall specify in what respects he finds that such deviation fails to meet the requirements of said sections. If such order is made after the expiration of the waiting period herein provided and any extension thereof made in accordance with this section, the order shall state when, within a reasonable period thereafter such filing shall be deemed no longer effective. Until an order of disapproval has become effective in accordance with the provisions of this section, such deviation shall be deemed to meet the requirements of sections 204.37 to 204.54. When said order of disapproval is made after the expiration of said waiting period or any extension thereof, said disapproval shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order. Such deviation shall be subject to the provisions of section 204.41 (4). In the event of an application for rehearing before the commissioner, he shall suspend his action in question pending the rehearing on such reasonable terms and conditions as he may impose. The action of the commissioner shall not become effective for a period of 10 days provided review proceedings are commenced within said period. The pendency of a review of any disapproval or other order of the commissioner made under the provisions of this section shall suspend such disapproval or order on such reasonable terms and conditions as may be imposed by the court. The aggrieved party shall make application to the court for an order fixing such terms and conditions within 10 days after commencement of such proceedings.

204.44 Appeal by minority to commissioner. (1) Any member of or subscriber to a rating organization may appeal to the commissioner from the action or decision of

such rating organization in approving or rejecting any proposed change in or addition to the filings of such rating organization and the commissioner shall, after a hearing held upon not less than 10 days' written notice to the appellant and to such rating organization, issue an order approving the action or decision of such rating organization or directing it to give further consideration to such proposal, or if such appeal is from the action or decision of the rating organization in rejecting a proposed addition to its filings he may in the event he finds that such action or decision was unreasonable issue an order directing the rating organization to make an addition to its filings on behalf of its members and subscribers, in a manner consistent with his findings, within a reasonable time after the issuance of such order.

(2) If such appeal is based upon the failure of the rating organization to make a filing on behalf of such member or subscriber which is based on a system of expense provisions which differs, in accordance with the right granted in section 204.39 (1) (b) from the system of expense provisions included in a filing made by the rating organization, the commissioner shall, if he grants the appeal, order the rating organization to make the requested filing for use by the appellant. In deciding such appeal the commissioner shall apply the standards set forth in section 204.39.

204.45 Information to be furnished insureds; hearings and appeals of insureds. (1) Every rating organization and every insurer which makes its own rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to such rate.

(2) Every rating organization and every insurer which makes its own rates shall provide within the state reasonable means whereby any person aggrieved by the application of its rating system may be heard in person or by his authorized representative on his written request to review the manner in which such rating system has been applied in connection with the insurance afforded him. If the rating organization or insurer fails to grant or reject such request within 30 days after it is made, the applicant may proceed in the same manner as if his application had been rejected. Any party affected by the action of such rating organization or such insurer on such request may, within 30 days after written notice of such action, appeal to the commissioner, who after a hearing held upon not less than 10 days' written notice to the appellant and to such rating organization or insurer may affirm or reverse such action.

204.46 Advisory organizations. (1) Every group, association or other organization of insurers, whether located within or outside this state, which assists insurers which make their own filings or rating organization in rate making by the collection and furnishing of loss or expense statistics or by the submission of recommendations but which does not make filings under ss. 204.37 to 204.54, shall be known as an advisory organization.

(2) Every advisory organization shall file with the commissioner (a) a copy of its constitution, its articles or agreement or association or its certificate of incorporation and of its by-laws, rules and regulations governing its activities, (b) a list of its members, (c) the name and address of a resident of this state upon whom notices or orders of the commissioner or process issued at his direction may be served, and (d) an agreement that the commissioner may examine such advisory organization in accordance with the provisions of section 204.48.

(3) If after a hearing the commissioner finds that the furnishing of such information or assistance involves any act or practice which is unfair or unreasonable or otherwise inconsistent with the provisions of sections 204.37 to 204.54 he may issue a written order specifying in what respects such act or practice is unfair or unreasonable or otherwise inconsistent with the provisions of said sections and requiring the discontinuance of such act or practice.

(4) No insurer which makes its own filings nor any rating organization shall support its filings by statistics or adopt rate making recommendations furnished to it by an advisory organization which has not complied with this section or with an order of the commissioner involving such statistics or recommendations issued under subsection (3). If the commissioner finds such insurer or rating organization to be in violation of this subsection he may issue an order requiring the discontinuance of such violation.

204.47 Joint underwriting or joint reinsurance. (1) Every group, association or other organization of insurers which engages in joint underwriting or joint reinsurance shall be subject to regulation with respect thereto as herein provided, subject however with respect to joint underwriting to all other provisions of ss. 204.37 to 204.54 and with respect to joint reinsurance to ss. 204.48 and 204.52 to 204.54.

(2) If after a hearing the commissioner finds that any activity or practice of any such group, association or other organization is unfair or unreasonable or otherwise incon-

sistent with the provisions of ss. 204.37 to 204.54, he may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of said sections and requiring the discontinuance of such activity or practice.

204.48 Examination of rating organizations. The commissioner shall at least once in 5 years make or cause to be made an examination of each rating organization licensed in this state as provided in section 204.42, and he may as often as he may deem it expedient make or cause to be made an examination of each advisory organization referred to in section 204.46 and of each group, association or other organization referred to in section 204.47. The reasonable cost of any such examination shall be paid by the rating organization, advisory organization, or group, association or other organization examined upon presentation to it of a detailed account of such cost. The officers, manager, agents and employes of such rating organization, advisory organization, or group, association or other organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation. The commissioner shall furnish 2 copies of the examination report to the organization, group or association examined and shall notify such organization, group or association that it may, within 20 days thereafter, request a hearing on said report or any facts or recommendations therein. Before filing any such report for public inspection the commissioner shall grant a hearing to the organization, group or association examined. The report of any such examination when filed for public inspection shall be admissible in evidence in any action or proceeding brought by the commissioner against the organization, group or association examined, or its officers or agents, and shall be prima facie evidence of the facts stated therein. The commissioner may withhold the report of any such examination from public inspection for such time as he may deem proper. In lieu of any such examination the commissioner may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of such state.

204.49 Rate administration. (1) RECORDING AND REPORTING OF LOSS AND EXPENSE EXPERIENCE. The commissioner shall promulgate reasonable rules and statistical plans, reasonably adapted to each of the rating systems on file with him which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid him in determining whether rating systems comply with the standards set forth in section 204.39. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating countrywide expense experience. In promulgating such rules and plans, the commissioner shall give due consideration to the rating systems on file with him and in order that such rules and plans may be as uniform as is practicable among the several states to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it. The commissioner may designate one or more rating organizations or other agencies to assist him in gathering such experience and making compilations thereof, and such compilations shall be made available subject to reasonable rules promulgated by the commissioner to insurers and rating organizations.

(2) INTERCHANGE OF RATING PLAN DATA. Reasonable rules and plans may be promulgated by the commissioner for the interchange of data necessary for the application of rating plans.

(3) CONSULTATION WITH OTHER STATES. In order to further uniform administration of rate regulatory laws, the commissioner and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to rate making and the application of rating.

(4) RULES AND REGULATIONS. The commissioner may make reasonable rules and regulations in conformity with and necessary to enforce the provisions of sections 204.37 to 204.54.

204.50 False or misleading information. No person or organization shall wilfully withhold information from or knowingly give false or misleading information to the commissioner, any statistical agency designated by the commissioner, any rating organization, or any insurer, which will affect the rates or premiums chargeable under sections 204.37 to 204.54. A violation of this section shall subject the one guilty of such violation to the penalties provided in s. 204.53.

204.51 Assigned risks. (1) Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the approval of the commissioner.

(2) Every insurer undertaking to transact in this state the business of automobile and motor vehicle bodily injury and property damage liability insurance and every rating organization which files rates for such insurance shall co-operate in the preparation and submission of a plan or plans for the equitable apportionment among insurers of applicants for insurance who are in good faith entitled to, but who are unable to procure through ordinary methods, such insurance. Such plan or plans shall provide: (a) Reasonable rules governing the equitable distribution of risks by direct insurance, reinsurance or otherwise and their assignment to insurers; (b) rates and rate modifications applicable to such risks which shall not be excessive, inadequate or unfairly discriminatory; (c) the limits of liability which the insurer shall be required to assume; (d) a method whereby applicants for insurance, insureds and insurers may have a hearing on grievances and the right of appeal to the commissioner. Every such plan shall be filed in writing with the commissioner. The commissioner shall review the plan as soon as reasonably possible after filing in order to determine whether it meets the requirements set forth in (a), (b), (c) and (d) above. Each plan unless sooner approved in writing shall be on file for a waiting period of 30 days before it becomes effective. A plan shall be deemed approved unless disapproved by the commissioner within the waiting period. Subsequent to the waiting period, the commissioner may disapprove any plan on the ground that it does not meet the requirements set forth in (a), (b), (c) and (d) above, but only after a hearing held upon not less than 10 days' written notice to every insurer and rating organization affected specifying the matters to be considered at such hearing, and only by an order specifying in what respect he finds that such plan fails to meet such requirements, and stating when within a reasonable period thereafter such plan shall be deemed no longer effective. Such order shall not affect any assignment made or policy issued or made prior to the expiration of the period set forth in said order. Amendments to such plan or plans shall be prepared, filed and reviewed in the same manner as herein provided with respect to the original plan or plans. If no plan meeting the standards set forth in (a), (b), (c) and (d) above is submitted to the commissioner within 90 days after June 30, 1949 or within the period stated in any order disapproving an existing plan he shall, if necessary to carry out the purpose of this section after hearing, prepare and promulgate a plan meeting such requirements. When such plan or plans or amendments thereto have been approved or promulgated, no insurer shall thereafter issue a policy of automobile and motor vehicle bodily injury and property damage liability insurance or undertake to transact such business in this state unless such insurer shall participate in such an approved or promulgated plan. If, after hearing, the commissioner finds that any activity or practice of any insurer or rating organization in connection with the operation of such plan or plans is unfair or unreasonable or otherwise inconsistent with the provisions of this subsection he may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this subsection and requiring the discontinuance of such activity or practice.

204.52 Rebates prohibited. (1) No agent shall knowingly charge, demand or receive a premium for any policy of insurance except in accordance with the provisions of sections 204.37 to 204.54. No insurer or employe thereof, and no agent shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever, not specified in the policy of insurance, except to the extent provided for in applicable filing. No insured named in a policy of insurance nor any employe of such insured shall knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, credit or reduction of premium, or any such special favor or advantage or valuable consideration or inducement. Nothing in this section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed agents nor as prohibiting any insurer from allowing or returning to its participating policyholders, members or subscribers, dividends, savings or unabsorbed premium deposits.

(2) As used in this section the word "insurance" includes suretyship and the word "policy" includes bond.

204.53 Penalties. (1) Any person or organization violating any provision of sections 204.37 to 204.54 shall be fined not more than $50 for each such violation, but if such

violation is found to be wilful, said person or organization may be fined not more than $500 for each such violation. Such fines may be in addition to any other penalty by law.

(2) The commissioner may suspend the license of any rating organization or insurer which fails to comply with an order of the commissioner within the time limited by such order or any extension thereof which the commissioner may grant. The commissioner shall not suspend the license of any rating organization or insurer for failure to comply with an order until the time prescribed for an appeal therefrom has expired or if an appeal has been taken until such order has been affirmed. The commissioner may determine when a suspension of license shall become effective and it shall remain in effect for the period fixed by him unless he modifies or rescinds such suspension or until the order upon which such suspension is based is modified, rescinded or reversed.

(3) No license shall be suspended or revoked except upon a written order of the commissioner, stating his findings, made after hearing held upon not less than 10 days' written notice to such person or organization specifying the alleged violation.

204.54 **Hearing procedure and judicial review.** (1) Any insurer or rating organization aggrieved by any order or decision of the commissioner under sections 204.37 to 204.54 made without a hearing, may within 30 days after notice of such order or decision to the insurer or organization make written request to the commissioner for a hearing thereon. The commissioner shall hear such party or parties within 20 days after receipt of such request and shall give not less than 10 days' written notice of the time and place of the hearing. Within 10 days after such hearing the commissioner shall affirm, reverse or modify his previous action, specifying his reasons therefor. Pending such hearing and decision thereon the commissioner may suspend or postpone the effective date of his previous action.

(2) Any approval, disapproval, order or decision of the commissioner under sections 204.37 to 204.54 made after a hearing shall be subject to review at the instance of any party in interest in the manner provided in chapter 227.

(3) The procedure in the conduct of hearings and making of approvals, disapprovals and any other orders by the commissioner under the provisions of sections 204.37 to 204.54 and the review thereof in court shall be governed by the provisions of chapter 227 of the statutes, except as far as they may be inconsistent with specific provisions of said sections. No application for rehearing or any rehearing shall be a condition precedent to review in court of any approval, disapproval or other order of the commissioner made under the provisions of said sections. In event of an application for rehearing before the commissioner, he shall stay his action in question pending the rehearing upon such reasonable terms and conditions as he may impose. The action of the commissioner shall not become effective for a period of 10 days provided review proceedings are commenced within said period. The pendency of a review of any disapproval or other order of the commissioner made under the provisions of said sections 204.37 to 204.54 shall suspend such disapproval or order on such reasonable terms and conditions as may be imposed by the court. The aggrieved party shall make application to the court for an order fixing such terms and conditions within 10 days after the commencement of such proceedings.