CHAPTER 632

INSURANCE CONTRACTS IN SPECIFIC LINES

SUBCHAPTER I

FIRE AND OTHER PROPERTY INSURANCE

632.05 Replacement cost of coverage. An insurer may agree in a property insurance policy to indemnify the insured for the amount it would cost to repair, rebuild or replace the damaged or destroyed insured property with new materials of like size, kind and quality.

History: 1975 c. 375.

Note: Chapter 375, laws of 1975, which created subchapters I to VIII of Chapter 632 of the statutes, contained notes explaining the revision. See the 1975 session law volume.

632.08 Mortgage clause. A provision for payment to a mortgagee or other owner of a security interest in property may be contained in or added by endorsement to any insurance policy protecting against loss or destruction of or damage to property. If the provision is contained in an endorsement and the insurance covers real property, any loss not exceeding $500 shall be paid to the insured mortgagor.

History: 1975 c. 375.

632.09 Choice of law. Every insurance against loss or destruction of or damage to property in this state or in the use of or income from property in this state is governed by the law of this state.

History: 1975 c. 375.

SUBCHAPTER II

SURETY INSURANCE

632.14 Bonds need not be under seal. No suretyship obligation need be under seal unless a seal is required by the applicable federal law or law of another jurisdiction.

History: 1975 c. 375.

632.17 Validity of surety bonds. (1) FAILURE TO FILE CERTIFICATE. No instrument executed by an insurer authorized to do a surety business is ineffective because of failure to file the certificate of its authority to do business in this state or a certified copy thereof; but the officer with whom any instrument so executed has been filed or any person who might claim the benefit thereof may by written notice require the person filing the instrument to have a certified copy of the certificate of authority filed with the officer, and unless the copy is filed within 8 days after receipt of the notice the instrument does not satisfy the requirement that the instrument be supplied.

(2) SATISFACTION OF OBLIGATIONS TO PROVIDE SURETY. An undertaking in appropriate terms issued by an insurer authorized to do a surety business satisfies and is complete compliance with any authorization or requirement in the law of this state respecting surety bonds, undertakings or other similar obligations, and shall be accepted as such by any official authorized to receive or empowered to require such an undertaking, subject to sub. (1).

History: 1975 c. 375.

SUBCHAPTER III

LIABILITY INSURANCE IN GENERAL

632.22 Required provisions of liability insurance policies. Every liability insurance policy shall provide that the bankruptcy or insolvency of the insured shall not diminish any liability of the insurer to 3rd parties and that if execution against the insured is returned unsatisfied, an action may be maintained against the insurer to the extent that the liability is covered by the policy.

History: 1975 c. 375.

632.23 Prohibited exclusions in aircraft insurance policies. No policy covering any liability arising out of the ownership, maintenance or use of an aircraft, may exclude or deny coverage because the aircraft is operated in violation of air regulation, whether derived from federal or state law or local ordinance.

History: 1975 c. 375.

632.24 Direct action against insurer. Any bond or policy of insurance covering liability to others for negligence makes the insurer liable, up to the amounts stated in the bond or policy, to the persons entitled to recover against the insured for the death of any person or for injury to persons or property, irrespective of whether the liability is presently established or is contingent and to become fixed or certain by final judgment against the insured.

History: 1975 c. 375.

632.25 Limited effect of conditions in employer's liability policies. Any condition in an employer's liability policy requiring compliance by the insured with rules concerning the safety of persons shall be limited in its effect in such a way that in the event of breach by the insured the insurer shall nevertheless be responsible to the injured person under s. 632.24 as if the condition has not been breached, but shall be subrogated to the injured person's claim against the insured and be entitled to reimbursement by the latter.

History: 1975 c. 375.

SUBCHAPTER IV

ANIMAL, AUTOMOBILE AND MOTOR VEHICLE INSURANCE

632.32 Required provisions for animal and automobile liability insurance. (1) NOTICE. Every policy of insurance against loss or damage for which the insured is liable, resulting from accident or injury to a person or loss or damage to property caused by animals or by any motor vehicle issued or delivered in this state may contain 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, is notice to the insurer, and a provision that failure to give any notice required by the policy within the time specified does not invalidate any claim made by the insured if it is shown not to have been reasonably possible to give the notice within the prescribed time and that notice was given as soon as reasonably possible.

(2) COVERAGE. (a) *Definition of automobile handler.* In this subsection, "automobile handler" means an automobile sales agency, repair shop, service station, storage garage or public parking place.

(b) *Required provisions.* Every policy of the kind specified in sub. (1) issued or delivered in this state to the owner of a motor vehicle shall contain a provision substantially as follows: "The coverage provided by this policy applies, in the same manner and under the same provision as it is applicable to the named insured, to any person while riding in or operating any automobile described in this policy when the automobile is being used for purposes and in the manner described in the policy. Such coverage also extends to any person legally responsible for the operation of the automobile." However, the policy may limit coverage to instances in which

the riding, use or operation is with the permission of the name insured, or if the insured is an individual with the permission of an adult member of the insured's household other than a chauffeur or domestic servant. In both cases such permission is permission without regard to s. 343.45 (2) or to whether the riding, use or operation is authorized by law. Any such policy issued to an automobile handler may provide that the coverage afforded to anyone other than the named insured, agents or employes may be restricted to the limits under s. 344.01 (2) (d) and applies only when there is no other valid and collectible insurance with at least those limits whether the other insurance is primary, excess or contingent. Any such policy issued to anyone other than an automobile handler may provide that the coverage afforded thereunder to any automobile handler or its agents or employes is restricted to the limits under s. 344.01 (2) (d) and applies only when there is no other valid and collectible insurance with at least those limits whether the other insurance is primary, excess or contingent. If an automobile covered by this policy is sold or transferred the purchaser or transferee is not an additional insured without consent of the insurer, endorsed on the policy. No such policy issued to any automobile handler may exclude coverage upon any of its officers, agents or employes when the officers, agents or employes are operating automobiles owned by customers doing business with the automobile handler.

(3) UNINSURED MOTORIST COVERAGE. (a) *Required coverage.* Every policy of insurance delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state and insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person arising out the ownership, maintenance or use of a motor vehicle shall provide therein or supplemental thereto in limits for bodily injury or death in the amount of at least $15,000 per person and $30,000 per accident under provisions approved by the commissioner, for the protection of persons injured who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness or disease, including death resulting therefrom. The uninsured motorist bodily injury coverage limits provided in such a policy may be made available to the insured up to the bodily injury coverage limits provided in the remaining portions of the policy.

(b) *Coverage in event of insolvency of insurer.* For purposes of this coverage, "uninsured motor vehicle" includes an insured motor vehicle if before or after the accident the liability insurer of the motor vehicle is declared insolvent by a court of competent jurisdiction. In that case, the insurer making payment under the uninsured motorists' coverage shall, to the extent of the payment, be subrogated to the rights of its insured.

History: 1975 c. 375, 421

See note to 344.33, citing Gross v. Joecks, 72 W (2d) 583, 241 NW (2d) 727.

Spouse who was not party to contract, reasonably believing that coverage existed after insured spouse's death, must be given grace period before having to comply with technical, not commonly known provisions of policy. Handal v. American Farmers Mut. Cas. Co. 79 W (2d) 67, 255 NW (2d) 903.

632.34 Provisions of motor vehicle liability policies. (1) DEFINITION AND SCOPE. "Motor vehicle liability policy" has the same meaning as in s. 344.33. This section applies only to motor vehicle liability policies and substitute means of security as described in sub. (2).

(2) EXCLUSION OF CERTAIN USES PROHIBITED. 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 may exclude from the coverage afforded or benefits provided any of the following:

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

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

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

(3) EXCLUSION OF RELATIVES PROHIBITED. No policy of insurance, agreement of indemnity or bond referred to in sub. (1) may exclude from the coverage afforded or benefits provided persons related by blood or marriage to the insured.

(4) NOTICE PROVISION. No policy of insurance, agreement of indemnity or bond as provided in sub. (1) may limit the time for the giving of notice of any accident or casualty covered thereby to less than 20 days. Failure to give notice does not bar liability under such policy of insurance, agreement of indemnity or bond if the insurer was not prejudiced by the failure, but the burden of proof is upon the person claiming there was no prejudice.

(5) NAMED INSURED COVERED. No policy of insurance, agreement of indemnity or bond referred to in sub. (1) may exclude from the coverage afforded or benefits provided liability on account of bodily injury, sickness or disease, including death resulting therefrom, sustained by any person who is a named insured.

(6) PASSENGERS COVERED. Every policy of insurance, agreement of indemnity or bond referred to in sub. (1) shall afford coverage in respect to liability on account of bodily injury, sickness or disease, including death resulting therefrom, sustained by any person who is a passenger in or on the insured vehicle.

(7) MEDICAL PAYMENTS COVERAGE. Every motor vehicle liability policy delivered or issued with respect to any motor vehicle registered or principally garaged in this state and insuring losses arising from liability for death or bodily injury of a person as a result of the ownership, maintenance or use of a motor vehicle shall provide therein or supplemental thereto, under provisions approved by the commissioner, medical payments or chiropractic payments or both in the amount of at least $1,000 per person for protection of all persons operating or riding in the insured vehicle from losses resulting from bodily injury or death. The named insured may reject the coverage. If the named insured rejects the coverage, it need not be provided in a subsequent renewal policy issued by the same insurer unless the insured requests it in writing. Under the medical or chiropractic payments coverage, the insurer shall be subrogated to the rights of its insured to the extent of its payments.

(8) DEFENSE OF NONCOOPERATION. Every motor vehicle liability policy shall, if it contains a provision providing a defense to the insurer for lack of cooperation on the part of the insured, provide also that the defense is not effective against a 3rd person making a claim against the insurer unless there was collusion between the 3rd person and the insured, or unless the claimant was a passenger in or on the insured vehicle. If the defense is not effective against the claimant, the insurer is subrogated to the injured person's claim against the insured and is entitled to reimbursement by the latter.

History: 1975 c. 375, 421.

"Family exclusion clause" valid in state of policy issuance will be given effect in Wisconsin. Knight v. Heritage Mut. Ins. Co. 71 W (2d) 821, 239 NW (2d) 348.

Fellow employe exclusion clause is only valid where tortfeasor and injured party are employes of the named insured and employer is required to provide worker's compensation coverage. Dahm v. Employers Mut. Liability Ins. Co. 74 W (2d) 123, 246 NW (2d) 131.

Trial court erred in finding that plaintiff insured failed to prove nonprejudicial effect of 12 month delay in notifying defendant insurer under (4). Ehlers v. Colonial Penn Ins. Co. 81 W (2d) 64, 259 NW (2d) 718.

632.35 Prohibited cancellation and nonrenewal. No insurer may cancel or refuse to renew an automobile insurance policy solely because of the age, sex, residence, race, color, creed, religion, national origin, ancestry, marital status or occupation of anyone who is an insured.

History: 1975 c. 375.

SUBCHAPTER V

LIFE INSURANCE AND ANNUITIES

632.41 Prohibited provisions in life insurance. (1) ASSESSABLE POLICIES. No insurer may issue assessable life insurance policies under which assessments or calls may be made upon policyholders or others.

(2) BURIAL INSURANCE. No contract in which the insurer agrees to pay for any of the incidents of burial may provide that the benefits are payable to an undertaker or any other person doing business related to burials.

(3) DEATH PRESUMED FROM ABSENCE. Section 813.22 (1) applies to all life insurance policies.

History: 1975 c. 373, 375, 422.

632.42 Trustee and deposit agreements in life insurance. (1) TRUSTEE AND OTHER AGREEMENTS. An insurer may hold as a part of its general assets the proceeds of any policy subject to this subchapter under a trust or other agreement upon such terms and restrictions as to revocation by the policyholder and control by the beneficiary and with such exemptions from the claims of creditors of the beneficiary as the insurer and the policyholder agree to in writing. An insurer may also receive funds in such amounts and upon such conditions, including the right of the policyholder to withdraw unused portions thereof, as the insurer and the policyholder agree to in writing:

(a) *Advance premiums.* As premiums in advance upon policies or annuities subject to this subchapter; or

(b) *New policies.* To accumulate for the purchase of future policies or annuities subject to this subchapter.

(2) ACCUMULATION OF FUNDS. Any insurer may, in connection with life insurance or annuity contracts, accept funds remitted to it under an agreement for an accumulation of the funds for the purpose of providing annuities or other benefits, under such reasonable rules as are prescribed by the commissioner.

History: 1975 c. 373, 375, 422.

632.43 Standard nonforfeiture law for life insurance. (1) On and after January 1, 1948, no policy of life insurance, except as stated in subsection (8), shall be issued or delivered in this state unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the defaulting or surrendering policyholder:

(a) In the event of default in any premium payment, the company will grant, upon proper

request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such value as may be hereinafter specified.

(b) Upon surrender of the policy within 60 days after the due date of any premium payment in default after premiums have been paid for at least 3 full years in the case of ordinary insurance or 5 full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified.

(c) A specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than 60 days after the due date of the premium in default.

(d) If the policy shall have become paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company will pay, upon surrender of the policy within 30 days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.

(e) A statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first 20 policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

(f) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

(g) The company shall reserve the right to defer the payment of any cash surrender value for a period of 6 months after demand therefor with surrender of the policy.

(h) Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

(2) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by subsection (1), shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of (a) the then present value of the adjusted premiums as defined in subsections (4), (5) and (6), corresponding to premiums which would have fallen due on and after such anniversary, and (b) the amount of any indebtedness to the company on the policy. Any cash surrender value available within 30 days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by subsection (1), shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

(3) Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

(4) Except as provided in sub. (5) (b), the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum

of (a) the then present value of the future guaranteed benefits provided for by the policy; (b) 2 per cent of the amount of insurance, if the insurance is uniform in amount, or of the equivalent uniform amount, as defined in sub. (5), if the amount of insurance varies with duration of the policy; (c) 40 per cent of the adjusted premium for the first policy year; (d) 25 per cent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less; provided, that in applying the percentages specified in (c) and (d), no adjusted premium shall be deemed to exceed 4 per cent of the amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this subsection and sub. (5) shall be the date as of which the rated age of the insured is determined.

(5) (a) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of sub. (4) and this subsection shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy; provided, that in the case of a policy providing a varying amount of insurance issued on the life of a child under age 10, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age 10 were the amount provided by such policy at age 10.

(b) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to: A) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by B) the adjusted premiums for such term insurance, the foregoing items A) and B) being calculated separately and as specified in par. (a) and sub. (4) except that, for the purposes of (b), (c) and (d) in sub. (4), the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in B) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in A).

(6) (a) Except as otherwise provided in par. (b) or (c), all adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of the commissioners 1941 standard ordinary mortality table, except that for any category of ordinary insurance issued on female risks adjusted premiums and present values may be calculated according to an age not more than 3 years younger than the actual age of the insured, and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 standard industrial mortality table. All calculations shall be made on the basis of the rate of interest, not exceeding 3 1/2 per cent per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; provided, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may not be more than 130 per cent of the rates of mortality according to such applicable table. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

(b) In the case of ordinary policies issued on or after the operative date of this paragraph, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the commissioners 1958 standard ordinary mortality table and the rate of interest, not exceeding 3.5% per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided that for any category of ordinary insurance issued on female risks adjusted premiums and present values may be calculated according to an age not more than 6 years younger than the actual age of the insured. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1958 extended term insurance table. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner. After June 14, 1959, any company may file with the commissioner a written notice of its election to comply with the provisions of this paragraph after a specified date before January 1, 1966. After the filing of such notice, then upon such specified date, which shall be the operative date

of this paragraph for such company, this paragraph shall become operative with respect to the ordinary policies thereafter issued by such company. If a company makes no such election, the operative date of this paragraph for such company shall be January 1, 1966.

(c) In the case of industrial policies issued on or after the operative date of this paragraph as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the commissioners 1961 standard industrial mortality table and the rate of interest, not exceeding 3 1/2 per cent per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; provided, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1961 industrial extended term insurance table, and for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table of mortality as is specified by the company and approved by the commissioner. After May 19, 1963, any company may file with the commissioner a written notice of its election to comply with this paragraph after a specified date before January 1, 1968. After the filing of such notice, then upon such specified date (which shall be the operative date of this paragraph for such company), this paragraph shall become operative with respect to the industrial policies thereafter issued by such company. If a company makes no such election, the operative date of this paragraph for such company shall be January 1, 1968.

(d) A rate of interest not exceeding 5.5% per annum may be used for ordinary policies or industrial policies, or both, issued on or after June 19, 1974, in lieu of the rate referred to in pars. (b) and (c).

(7) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in subs. (2), (3), (4), (5) and (6) may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the dividends used to provide such additions. Notwithstanding the provisions of sub. (2), additional benefits payable: (a) in the event of death or dismemberment by accident or accidental means, (b) in the event of total and permanent disability, (c) as reversionary annuity or deferred reversionary annuity benefits, (d) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply, (e) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is 26, is uniform in amount after the child's age is one, and has not become paid up by reason of the death of a parent of the child, and (f) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(8) This section shall not apply to any reinsurance, group insurance, pure endowment, annuity or reversionary annuity contract, nor to any term policy of uniform amount, or renewal thereof, of 20 years or less expiring before age 66, for which uniform premiums are payable during the entire term of the policy, nor to any term policy of decreasing amount on which each adjusted premium, calculated as specified in subsections (4), (5) and (6), is less than the adjusted premium so calculated, on such 20 year term policy issued at the same age and for the same initial amount of insurance, nor to any policy which shall be delivered outside this state through an agent or other representative of the company issuing the policy.

(9) After May 22, 1943, any company may file with the commissioner a written notice of its intention to comply with the provisions hereof after a specified date before January 1, 1948. After the filing of such notice, then upon such specified date, this section shall become fully effective with respect to policies thereafter issued by such company and all previously existing provisions of law inconsistent with this section shall become inapplicable to such policies. Except as herein provided, this section shall become effective January 1, 1948, and shall from and after said date supersede all provisions of law inconsistent or in conflict therewith.

History: 1973 c. 303; 1977 c. 153 s. 1; 1977 c. 339 s. 15.

632.435 Standard nonforfeiture law for individual deferred annuities. (1) In the case of contracts issued on or after the operative date of this section as defined in sub. (12), no contract of annuity shall be delivered or issued for delivery in this state unless it contains in

substance the following provisions or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contract holder:

(a) Upon cessation of payment of considerations under a contract the company will grant a paid-up annuity on a plan stipulated in the contract of such value as is specified in subs. (5) to (8) and (10).

(b) If a contract provides for a lump sum settlement at maturity or at any other time, upon surrender of the contract at or prior to the commencement of any annuity payments, the company will pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in subs. (5), (6), (8) and (10). The company shall reserve the right to defer the payment of such cash surrender benefit for a period of 6 months after demand therefor with surrender of the contract.

(c) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits.

(d) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

(e) Notwithstanding the requirements of this subsection, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of 2 years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than $20 monthly, the company may terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

(4) The minimum values as specified in subs. (5) to (8) and (10) of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as follows:

(a) With respect to contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at a rate of interest of 3% per annum of percentages of the net considerations paid prior to such time, decreased by the sum of any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of 3% per annum and the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. The net considerations for a given contract year for purposes of this subsection shall be an amount not less than zero and shall be equal to the corresponding gross considerations credited to the contract during the contract year less an annual contract charge of $30 and less a collection charge of $1.25 per consideration credited to the contract during that contract year. The percentages of net considerations shall be 65% of the net consideration for the first contract year and 87.5% of the net considerations for the 2nd and later contract years, except that the percentage shall be 65% of the portion of the total net consideration for any renewal contract year which exceeds by not more than 2 times the sum of those portions of the net considerations in all prior contract years for which the percentage was 65%.

(b) With respect to contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be defined as for contracts with flexible considerations which are paid annually except that:

1. The portion of the net consideration for the first contract year to be accumulated shall be the sum of 65% of the net consideration for the first contract year plus 22.5% of the excess of the net consideration for the first contract year over the lesser of the net considerations for the 2nd and 3rd contract years.

2. The annual contract charge shall be the lesser of $30 or 10% of the gross annual consideration.

(c) With respect to contracts providing for a single consideration, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except that the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to 90% and the net consideration shall be the gross consideration less a contract charge of $75.

(5) Any paid-up annuity benefit available under a contract shall be such that its present

value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(6) For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. No cash surrender benefit shall be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(7) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the company to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit, but the present value of a paid-up annuity benefit shall be not less than the minimum nonforfeiture amount at that time.

(8) For the purpose of determining the benefits calculated under subs. (6) and (7), in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's 70th birthday or the 10th anniversary of the contract, whichever is later.

(9) Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

(10) Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(11) For any contract which provides within the same contract, by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding subs. (5) to (8) and (10), additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

(12) After November 8, 1977, any company may file with the commissioner a written notice of its election to comply with this section after a specified date before the 2nd anniversary of November 8, 1977. After the filing of such notice, then upon such specified date, which shall be the operative date of this section for

such company, this section shall become operative with respect to annuity contracts thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be the 2nd anniversary of November 8, 1977.

(13) This section does not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship), an employe organization or both (other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the U.S. internal revenue code, as now or hereafter amended), premium deposit fund, variable annuity, investment annuity, immediate annuity, deferred annuity contract after annuity payments have commenced, reversionary annuity or any contract which is delivered outside this state through an agent or other representative of the company issuing the contract.

History: 1977 c. 153.

632.44 Required provisions in life insurance. (1) SEPARATE BENEFITS. Every life insurance policy shall specify separately each benefit promised in the policy.

(2) GRACE PERIOD. Every life insurance policy other than a group policy shall contain a provision entitling the policyholder to a grace period of not less than 31 days for the payment of any premium due except the first, during which the death benefit shall continue in force.

(3) CREDIT LIFE. (a) Individual credit life insurance policies shall be for nonrenewable, nonconvertible, term insurance. This restriction does not apply when evidence of insurability is required nor when the credit transaction is for more than 5 years.

(b) When the insured debtor has paid or has made an obligation to pay all or any part of the premium under an individual credit life insurance policy, the total charge to the debtor shall be shown in the policy issued to the insured debtor. However, the rate of charge to the debtor rather than the total charge may be shown where the indebtedness is variable from period to period and the premium is computed periodically on the outstanding balance. The policy shall contain provision for cancellation of insurance upon termination of indebtedness through prepayment and shall provide for a refund of any unearned charge to the debtor, computed on a formula filed with the commissioner.

(c) The insurer shall fully control and be responsible for the settlement or adjustment of all claims.

History: 1975 c. 375, 421.

632.45 Contracts providing variable benefits. (1) IDENTIFICATION. Any contract issued under s. 611.25 or under any section of the code incorporating s. 611.25 by reference which provides for payment of benefits in variable amounts shall contain a statement of the essential features of the procedure to be followed by the insurer in determining the dollar amount of the variable benefits. It shall contain appropriate nonforfeiture benefits in lieu of those under s. 632.43. Any such individual contract and any such certificate issued under a group contract shall state that the dollar amount may decrease or increase and shall conspicuously display on its first page a statement that the benefits thereunder are on a variable basis, with a statement where in the contract the details of the variable provisions may be found.

(2) AMENDMENTS. Any contract under sub. (1) shall state whether it may be amended as to investment policy, voting rights, and conduct of the business and affairs of any segregated account. Subject to any preemptive provision of federal law, any such amendment is subject to filing and approval under s. 631.20 and approval by a majority of the policyholders in the segregated account.

(3) MARKETING PLAN. Contracts under sub. (1), if they are not forms, may be issued only within the terms of a general marketing plan approved by the commissioner. The marketing plan shall be designed to protect the interests of the policyholders in regard to any voting rights and operation of the segregated account and amendment of the contract.

History: 1975 c. 375; 1977 c. 153 s. 6; 1977 c. 339 s. 44.

632.46 Incontestability and misstated age. (1) INCONTESTABILITY OF INDIVIDUAL POLICIES. Except under sub. (3) or (4) or for nonpayment of premiums, no individual life insurance policy may be contested after it has been in force from the date of issue for 2 years during the lifetime of the person whose life is at risk.

(2) INCONTESTABILITY OF GROUP POLICIES. Except under sub. (3) or (4) or for nonpayment of premiums, no group life insurance policy may be contested after it has been in force for 2 years from its date of issue and no coverage of any insured thereunder may be contested on the basis of a statement made by the insured relative to his or her insurability after the coverage has been in force on the insured for 2 years during the lifetime of the insured. No such statement

may be used to contest coverage unless contained in a written instrument signed by the insured person.

(3) MISSTATED AGE. (a) Subject to par. (b), if the age of the person whose life is at risk is misstated in an application for a policy of life insurance and the error is not adjusted during the person's lifetime the amount payable under the policy is what the premium paid would have purchased if the age had been stated correctly.

(b) If the person whose life is at risk was, at the time the insurance was applied for, beyond the maximum age limit designated by the insurer, the insurer shall refund at least the amount of the premiums collected under the policy.

(4) DISABILITY COVERAGES AND ADDITIONAL ACCIDENT BENEFITS. Despite subs. (1) and (2), disability coverages and additional accident benefits may be contested at any time on the ground of fraudulent misrepresentation.

History: 1975 c. 373, 375, 422.

632.47 Assignment of life insurance rights. (1) GENERAL. Except as provided in sub. (3), the owner of any rights under a life insurance policy or annuity contract may assign any of those rights, including any right to designate a beneficiary and the rights secured under s. 632.57 or any other statute. An assignment valid under general contract law vests the assigned rights in the assignee subject, so far as reasonably necessary for the protection of the insurer, to any provisions in the insurance policy or annuity contract inserted to protect the insurer against double payment or obligation.

(2) RELATIVE RIGHTS OF ASSIGNEE AND BENEFICIARY. The rights of a beneficiary under a life insurance policy or annuity contract are subordinate to those of an assignee, unless the beneficiary was effectively designated as an irrevocable beneficiary prior to the assignment.

(3) GROUP ANNUITIES. Assignment may be expressly prohibited by a group contract providing annuities as retirement benefits.

History: 1975 c. 373, 375, 422.

632.48 Designation of beneficiary. (1) POWERS OF POLICYHOLDERS. Subject to s. 632.47 (2), no life insurance policy or annuity contract may restrict the right of a policyholder or certificate holder:

(a) *Irrevocable designation of beneficiary.* To make at any time an irrevocable designation of beneficiary effective at once or at some subsequent time; or

(b) *Change of beneficiary.* If the designation of beneficiary is not explicitly irrevocable, to change the beneficiary without the consent of the previously designated beneficiary. Subject to s. 853.17, as between the beneficiaries, any act that unequivocally indicates an intention to make the change is sufficient to effect it.

(2) PROTECTION OF INSURER. An insurer may prescribe formalities to be complied with for the change of beneficiaries, which may be only for its own protection. The insurer discharges its obligation under the insurance policy or certificate of insurance if it pays a properly designated beneficiary unless it has actual notice of either an assignment or a change in beneficiary designation made pursuant to sub. (1) (b). It has actual notice if the prescribed formalities are complied with.

History: 1975 c. 373, 375, 422.

632.50 Estoppel from medical examination. If under the rules of any insurer issuing life insurance, its medical examiner has authority to issue a certificate of health, or to declare the proposed insured acceptable for insurance, and so reports to the insurer or its agent, the insurer is estopped to set up in defense of an action on the policy issued thereon that the proposed insured was not in the condition of health required by the policy at the time of issue or delivery, or that there was a preexisting condition not noted in the certificate or report, unless the certificate or report was procured through the fraudulent misrepresentation or nondisclosure by the applicant or proposed insured.

History: 1975 c. 375.

632.55 Limitations on group life insurance. (1) NATURE OF GROUP. No group life insurance policy may be issued on any group unless the group is formed in good faith for purposes other than to obtain insurance.

(2) SIZE OF POLICIES. No policy of group term life insurance may be issued on any group which, together with any other term life insurance policy on the same group, provides insurance on any one insured life in excess of $100,000. This limitation of amount does not apply to any such group policy existing on July 15, 1949, or to any amount thereafter written under the policy or any amendments or substitution thereof.

History: 1975 c. 371, 373, 375, 422.

632.56 Required group life insurance provisions. Every group life insurance policy shall contain the following:

(1) EVIDENCE OF INSURABILITY. A provision setting forth any conditions under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of that coverage.

(2) MISSTATEMENT OF AGE. A provision specifying that an equitable adjustment of premiums or of benefits or of both will be made if the age of an insured person has been misstated and clearly stating the method of adjustment.

(3) FACILITY OF PAYMENT. A provision that any sum becoming due by reason of the death of an insured person is payable to the beneficiary designated by the insured person, subject to policy provisions if there is no designated beneficiary, and to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of the sum not exceeding $1,000 to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the insured person. This subsection does not apply to a policy issued to a creditor to insure his or her debtors.

(4) NONFORFEITURE. If it is not term insurance, equitable nonforfeiture provisions, but they need not be the same provisions as are in individual policies.

(5) GRACE PERIOD. A provision that the policyholder is entitled to a grace period of not less than 31 days for the payment of any premium due except the first. During the grace period the death benefit coverage shall continue in force, unless the policyholder gives the insurer advance written notice of discontinuance in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

History: 1975 c 375, 421.

632.57 Conversion option in group and franchise life insurance. (1) SCOPE OF APPLICATION. This section applies to all group life insurance policies other than credit life insurance policies and applies to franchise life insurance policies providing term insurance renewable only while the insured is a member of the franchise unit.

(2) CONVERSION RIGHT UPON LOSS OF ELIGIBILITY. (a) If the insurance, or any portion of it, on a person insured under a policy covered by this section ceases because of termination of employment or of membership in the class or franchise unit eligible for coverage, the insurer shall, upon written application and payment of the first premium within 31 days after the termination, issue to the person, without evidence of insurability, an individual policy providing benefits reasonably similar in type and amount to those of the group or franchise insurance, but which need not include disability or other supplementary benefits.

(3) TERMS OF CONVERSION. (a) *Form of policy.* The individual policy shall, at the option of the applicant, be on any form then customarily issued by the insurer, except term insurance, at the age and for the amount applied for.

(b) *Amount of coverage.* The individual policy shall, at the option of the applicant, be in an amount as large as in the group or franchise life insurance which ceases, less any amount of insurance which has then matured as an endowment payable to the insured person, whether in one sum or in instalments or in the form of an annuity.

(c) *Premium rates.* The premium on the individual policy shall be at the customary rate then applied generally by the insurer to policies in the form and amount of the individual policy, to the class of risk to which the person then belongs without applying individual underwriting considerations, except as to occupation or avocation, and to the person's age on the effective date of the individual policy.

(4) CONVERSION UPON TERMINATION OF GROUP INSURANCE. If the group or franchise policy terminates or is amended so as to terminate the insurance of any class of insured persons, the insurer shall, on written application and payment of the first premium within 31 days after the termination, issue to any person whose insurance is thus terminated or amended, after having been in effect for at least 5 years, an individual policy on the same conditions as in subs. (2) and (3), less the amount of any other group or franchise insurance made available to the person within 31 days thereafter as a consequence of the termination or amendment. The group policy may provide that the maximum amount of insurance available under this subsection is an amount not less than $2,000 without a conversion charge and an additional amount not less than $3,000 by paying the insurer's usual conversion charge on the additional amount.

(5) EXTENSION OF CLAIMS UNDER GROUP OR FRANCHISE POLICY. If a person insured under the group or franchise policy dies during the conversion period under sub. (2) to (4) and before an individual policy is effective, the amount of life insurance which the person would have been entitled to have issued as an individual policy shall be payable as a claim under the group or franchise policy, whether or not the person has applied for the individual policy or paid the first premium.

History: 1975 c. 375, 421.

632.60 Limitation on credit life insurance. Nothing in this code authorizes licensees under

s. 138.09 to require or accept insurance not permitted under s. 138.09 (7) (h).

History: 1975 c. 375.

632.62 Participating and nonparticipating policies. (1) AUTHORIZATION. (a) *Stock insurers.* A stock insurer may issue both participating and nonparticipating life insurance policies, subject to this section.

(b) *Fraternals and mutual insurers.* A fraternal or mutual insurer issuing life insurance policies may issue only participating policies, except for the following situations in which it may issue nonparticipating policies:

1. Paid-up, temporary, pure endowment insurance and annuity settlements provided in exchange for lapsed, surrendered or matured policies;

2. Annuities beginning within one year of the making of the contract; and

3. Such term insurance policies as the commissioner may exempt by rule.

(2) PARTICIPATION. Every participating policy shall by its terms give its holder full right to participate annually in the part of the surplus accumulations from the participating business of the insurer that are to be distributed.

(3) ACCOUNTING. Every insurer issuing both participating and nonparticipating policies shall separately account for the 2 classes of business and no part of the amounts accumulated or credited to the participating class may be voluntarily transferred to the nonparticipating class.

(4) DIVIDEND PAYMENTS. (a) *Deferred dividends.* No life insurance policy or certificate may be issued in which the accounting, apportionment and distribution of surplus is deferred for a period longer than one year.

(b) *Payment.* Every insurer doing a participating business shall annually ascertain the surplus over required reserves and other liabilities. After setting aside such contingency reserves as may be considered necessary and be lawful, such reasonable nondistributable surplus as is needed to permit orderly growth, making provision for the payment of reasonable dividends upon capital stock and such sums as are required by prior contracts to be held on account of deferred dividend policies, the remaining surplus shall be equitably apportioned and returned as a dividend to the participating policyholders or certificate holders entitled to share therein. A dividend may be conditioned on the payment of the succeeding year's premium only on the first and second anniversaries of the policy.

History: 1975 c. 373, 375, 422.

SUBCHAPTER VI

DISABILITY INSURANCE

632.71 Estoppel from medical examination, assignability and change of beneficiary. Sections 632.47 to 632.50 apply to disability insurance policies.

History: 1975 c. 373, 375, 422.

632.72 Medical assistance; assignment. The providing of medical benefits under s. 49.02, 49.03 or 49.046 or of medical assistance under s. 49.45, 49.46 or 49.47 constitutes an assignment to the department of health and social services or the county or municipality providing the medical benefits or assistance. The assignment shall be, to the extent of the medical benefits or assistance provided, for benefits to which the recipient would be entitled under any policy of health and disability insurance.

History: 1977 c. 29.

632.73 Right to return policy. (1) RIGHT OF RETURN. A policyholder may return any individual or franchise disability policy within 10 days after receipt. If the policyholder does so, the contract is void, and all payments made under it shall be refunded.

(2) NOTIFICATION. Sub. (1) shall in substance be conspicuously printed on the first page of each such policy or conspicuously attached thereto.

(3) EXEMPTIONS. (a) *Specified.* This section does not apply to single premium nonrenewable policies issued for terms not greater than 6 months or covering accidents only or accidental bodily injuries only.

(b) *By rule.* The commissioner may by rule permit exemptions from subs. (1) and (2) for additional classes or parts of classes of insurance where the right to return the policy would be impracticable or is not necessary to protect the policyholder's interests.

History: 1975 c. 375, 421.

632.74 Reinstatement of individual or franchise disability insurance policies. (1) CONDITIONS OF REINSTATEMENT. If an insurer, after having canceled an individual or franchise disability insurance policy for nonpayment of premium, within one year after the cancellation accepts without reservation a premium payment covering more than the period of time for which premiums remained unpaid prior to the effective date of the cancellation, the policy is reinstated as of the date of the acceptance. There is no acceptance without reservation if the insurer

delivers or mails a written statement of reservations within 30 days after receipt of the payment.

(2) CONSEQUENCES OF REINSTATEMENT. If a policy is reinstated under sub. (1) or if the insurer within one year after the termination issues to the policyholder a reinstatement policy, any losses resulting from accidents occurring or sickness beginning between the termination and the effective date of the reinstatement or the new policy are not covered, and no premium is payable for that period, except to the extent that the premium is applied to a reserve for future losses. The insurer may also charge a reinstatement fee in accordance with a schedule that has been filed with and expressly approved by the commissioner as not excessive and not unreasonably discriminatory. In all other respects, the reinstated or renewed contract shall be treated as an uninterrupted contract.

History: 1975 c. 375

632.75 Prohibited provisions for disability insurance. (1) DEATH PRESUMED FROM EXTENDED ABSENCE. Section 813.22 (1) applies to any disability insurance policy providing a death benefit.

(2) DIVIDENDS CONDITIONED ON CONTINUATION OF POLICY OR PAYMENT OF PREMIUMS. Except on the first or second anniversary, no dividend payable on a disability insurance policy may be made contingent on the continuation of the policy or on premium payments.

History: 1975 c. 375

632.76 Incontestability for disability insurance. (1) AVOIDANCE FOR MISREPRESENTATIONS. No statement made by an applicant in the application for individual disability insurance coverage and no statement made respecting the person's insurability by a person insured under a group policy, except fraudulent misrepresentation, is a basis for avoidance of the policy or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for 2 years. The policy may provide for incontestability even with respect to fraudulent misstatements.

(2) PREEXISTING DISEASES. No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss.

History: 1975 c. 375, 421

632.77 Permitted provisions for disability insurance policies. If any provisions are contained in a disability insurance policy dealing with the following subjects, they shall conform to the requirements specified:

(1) CHANGE OF OCCUPATION. Any provision respecting change of occupation may provide only for a lower maximum payment and for reduction of loss payments proportionate to the change in appropriate premium rates if the change is to a higher rated occupation, and must provide for retroactive reduction of premium rates at least to the last policy anniversary date if the change is to a lower rated occupation.

(2) MISSTATEMENT OF AGE. Any provision respecting misstatement of age may only provide for reduction of the loss payable to the amount that the premium paid would have purchased at the correct age.

(3) LIMITATIONS ON PAYMENTS. Any limitation on payments because of other insurance or because of the income of the insured must be in accordance with provisions approved by the commissioner by rule or explicitly approved in approving the policy form.

(4) FACILITY OF PAYMENT. Reasonable facility of payment clauses may be inserted. Payment in accordance with such clauses shall discharge the insurer's obligation to pay claims.

History: 1975 c. 375

632.78 Required provisions for disability insurance policies. (1) GRACE PERIOD. Every disability insurance policy shall contain clauses providing for a grace period of at least 7 days for weekly premium policies, 10 days for monthly premium policies and 31 days for all other policies, for each premium after the first, during which the policy shall continue in force. In group and blanket policies the policy must provide for a grace period of at least 31 days unless the policyholder gives written notice of discontinuance prior to the date of discontinuance and in accordance with the policy terms. In group or blanket policies, the policy may provide for payment of a pro rata premium for the period the policy is in effect during the grace period under this subsection.

(2) KIDNEY DISEASE TREATMENT. Every disability insurance policy which provides hospital treatment coverage on an expense incurred basis shall contain a clause providing for coverage for hospital inpatient and outpatient kidney disease treatment, which may be limited to dialysis, transplantation and donor-related services, in an amount not less than $30,000 annually, as defined by the department of health and social services under s. 632.89 (6). No insurer is required to duplicate coverage available under

the federal medicare program, nor duplicate any other insurance coverage the insured may have. Coverage under this subsection may not be subject to exclusions or limitations, including deductibles and coinsurance factors, which are not generally applicable to other conditions covered under the policy.

(3) HOME CARE. (a) Every disability insurance policy which provides coverage of expenses incurred for in-patient hospital care shall provide coverage for the usual and customary fees for home care. Such coverage shall be subject to the same deductible and coinsurance provisions of the policy as other covered services. The maximum weekly benefit for such coverage need not exceed the usual and customary weekly cost for care in a skilled nursing facility. If an insurer provides disability insurance, or if 2 or more insurers jointly provide disability insurance, to an insured under 2 or more policies, home care coverage is required under only one of the policies.

(b) In this subsection "disability insurance" means surgical, medical, hospital, major medical and other health service coverage but does not include hospital indemnity policies or ancillary coverages such as income continuation, loss of time or accident benefits.

(c) In this subsection "home care" means care and treatment of an insured under a plan of care established, approved in writing and reviewed at least every 2 months by the attending physician, unless the attending physician determines that a longer interval between reviews is sufficient, and consisting of one or more of the following:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse.

2. Part-time or intermittent home health aide services which are medically necessary as part of the home care plan, under the supervision of a registered nurse or medical social worker, which consist solely of caring for the patient.

3. Physical, respiratory, occupational or speech therapy.

4. Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a hospital, if necessary under the home care plan, to the extent such items would be covered under the policy if the insured had been hospitalized.

5. Nutrition counseling provided by or under the supervision of a registered dietician where such services are medically necessary as part of the home care plan.

6. The evaluation of the need for and development of a plan, by a registered nurse, physician extender or medical social worker, for home care when approved or requested by the attending physician.

(cm) In this subsection "hospital indemnity policies" means policies which provide benefits in a stated amount for confinement in a hospital, regardless of the hospital expenses actually incurred by the insured, due to such confinement.

(d) In this subsection "immediate family" means the spouse, children, parents, grandparents, brothers and sisters of the insured and their spouses.

(e) Home care shall not be reimbursed unless the attending physician certifies that:

1. Hospitalization or confinement in a skilled nursing facility would otherwise be required if home care was not provided.

2. Necessary care and treatment are not available from members of the insured's immediate family or other person's residing with the insured without causing undue hardship.

3. The home care services shall be provided or coordinated by a state-licensed or medicare-certified home health agency or certified rehabilitation agency.

(f) If the insured was hospitalized immediately prior to the commencement of home care, the home care plan shall also be initially approved by the physician who was the primary provider of services during the hospitalization.

(g) Each visit by a person providing services under a home care plan or evaluating the need for or developing a plan shall be considered as one home care visit. The policy may contain a limit on the number of home care visits, but not less than 40 visits in any 12-month period, for each person covered under the policy. Up to 4 consecutive hours in a 24-hour period of home health aide service shall be considered as one home care visit.

(h) Every disability insurance policy which purports to provide coverage supplementing parts A and B of Title XVIII of the social security act shall make available and if requested by the insured provide coverage of supplemental home care visits beyond those provided by parts A and B, sufficient to produce an aggregate coverage of 365 home care visits per policy year.

(i) This subsection does not require coverage for any services provided by members of the insured's immediate family or any other person residing with the insured.

(j) Insurers reviewing the certified statements of physicians as to the appropriateness and medical necessity of the services certified by the physician under this subsection may apply the same review criteria and standards which are utilized by the insurer for all other business.

History: 1975 c. 375; 1977 c. 371.

632.79 Notice of termination of group hospital, surgical or medical expense insurance coverage due to cessation of business or default in payment of premiums. **(1)** SCOPE. This section shall apply to every group hospital, surgical or medical expense insurance policy or service plan purchased by or on behalf of an employer to provide coverage for employes and issued under authority of s. 148.03 [1973 Stats.], 182.032 [1973 Stats.], 185.981, 200.26 [1973 Stats.], 201.04 (4) [1973 Stats.] or 204.321 [1973 Stats.] which has been delivered, renewed or is otherwise in force on or after June 12, 1976.

(2) NOTICE TO POLICYHOLDER OR PARTY RESPONSIBLE FOR PAYMENT OF PREMIUMS. (a) Prior to termination of any group policy, plan or coverage subject to this section due to a cessation of business or default in payment of premiums by the policyholder, trust, association or other party responsible for such payment, the insurer or organization issuing the policy, contract, booklet or other evidence of insurance shall notify in writing the policyholder, trust, association or other party responsible for payment of premiums of the date as of which the policy or plan will be terminated or discontinued. At such time, the insurer or organization shall additionally furnish to the policyholder, trust, association or other party a notice form in sufficient number to be distributed to covered employes or members indicating what rights, if any, are available to them upon termination.

(b) For purpose of notice and distribution to covered employes and members under par. (a) and notice to the commissioner of insurance under sub. (3), the administrator responsible for determining the persons covered and the premiums payable to the insurer or organization under any group policy or plan of the type described in s. 204.321 (1) (b) or (c) [1973 Stats.] is responsible for providing such notices.

(3) NOTICE TO COMMISSIONER OF INSURANCE. At the time notice is provided under sub. (2) to the policyholder, trust, association or other party responsible for payment of premiums, the insurer or organization shall provide similar written notice to the commissioner of insurance specifying the name and address of the group policyholder and the employer involved, the date when the policy, plan or coverage will be terminated, and any additional information the commissioner may require.

(4) LIABILITY OF INSURER OR SERVICE ORGANIZATION FOR PAYMENT OF CLAIMS. Under any group policy or plan subject to this section, the insurer or organization shall be liable for all valid claims for covered losses prior to the expiration of any grace period specified in the group policy or plan or prior to the 15th day following receipt by the commissioner of insurance of the notice required under sub. (3), whichever is later.

(5) NOTICE TO COVERED EMPLOYES OR MEMBERS. Upon receipt of any notice of termination of coverage required under sub. (3), the commissioner of insurance shall promptly publish a class 2 notice, under ch. 985, of such termination to covered employes or members in an official newspaper and a newspaper of general circulation, if any, serving the locality of the employer's place of business. Such notice shall include the name and business address of the employer, the name and address of the insurer or organization, the date on which coverage will terminate, and any additional information the commissioner deems pertinent for the protection of covered employes or members.

(6) NOTICE EXCEPTION. The notice requirements of this section shall not apply if a group policy or plan providing coverage to employes or members is terminated and immediately replaced by another policy or plan providing similar coverage to such employes or members.

History: 1975 c. 352; 1975 c. 422 s. 106.

Legislative Council Note, 1975: This section requires insurance companies and service organizations issuing group hospital, surgical or medical expense insurance policies and plans covering groups of employes to provide advance notice whenever coverage is to be terminated due to a default in the payment of premiums or a cessation of the employer's business.

In such instances, notice of termination must be given to both the employer, or other party responsible for the payment of premiums, who shall directly notify affected employes, and to the commissioner of insurance. The commissioner is then required to provide additional notice of termination of coverage to affected employes by promptly publishing such notice in the local newspaper.

In addition, the bill provides that an insurance company or service organization shall remain liable for all valid claims incurred by employes under the group policy or plan until the expiration of any grace period for late premium payments as may be provided in the group contract or until the 15th day after notice of termination is received by the commissioner, whichever is later.

The administrator of any multiemployer group insurance trust or plan covering employes would also be required to provide the above notices, and for such purpose the administrator is deemed the agent of the insurer or service organization. Finally, an exemption from the notice requirements is provided where a group policy is terminated and immediately replaced by similar group coverage for the same employes. [Bill 594-A]

632.80 Restrictions on medical payments insurance. The provisions of this subchapter do not apply to medical payments insurance when it is a part of or supplemental to liability, steam boiler, elevator, automobile or other insurance covering loss of or damage to property, provided the loss, damage or expense arises out of a hazard directly related to such other insurance.

History: 1975 c. 375.

632.86 Restrictions on choice of health care services or professionals. Subject to any power given by statute to the commissioner

to disapprove the form, a contract providing a plan of health care services or payment therefor may limit its application to such hospitals, other health care services or health care professionals as have agreed to participate in the plan and abide by its terms. No such contract may place on the person covered thereunder the obligation of choosing nor give the corporation the right to require the choice of any particular health care service or professional among those contracting with the corporation, except by requiring the selection of primary providers to be used when reasonably possible.

History: 1975 c. 223.

Legislative Council Note, 1975: This is essentially s. 182.032 (3) (c), and a small part of s. 182.032 (2) (f), 185.982 (1) (second and third sentences), and s. 148.03 (1) (last sentence), and corresponding provisions in the enabling acts of other health care services. See also comment on s. 628.37. It is made applicable to commercial insurers to implement the policy contained in ss. 204.31 (3) (a) 9.b., 204.321 (2) (c) and 204.33. Freedom of choice among the contracting hospitals has been thought desirable by the legislature in the past. The requirement of selection of primary providers may be essential for the operation of some of HMO's. It compels the participant to make his selection in advance of the need for the service, to facilitate arranging the logistics of the plan. [Bill 17-S]

632.87 Restrictions on health care services. No insurer may refuse to provide or pay for benefits for health care services provided by a licensed health care professional on the ground that they were not rendered by a physician as defined in s. 990.01 (28), unless the contract clearly excludes services by such practitioners.

History: 1975 c. 223, 371, 422.

Legislative Council Note, 1975: This continues (and expands the scope of) s. 207.04 (1) (k) [repealed by this act], which does not deal with an unfair marketing practice but an unduly restrictive interpretation of an insurance contract. Presently it applies only to podiatrists but the same principles apply to all health care professionals. Since the legislature has licensed podiatrists (s. 448.10 et. seq.), as well as other health care professionals who are not physicians, applicable insurance contracts should provide benefits for their services or payment to them, as well as for those of physicians, unless they are specifically and clearly excluded by a policy which has been approved by the commissioner. But general principles of freedom of contract should be operative if the contract is clear enough. Parties negotiating for insurance coverage should be free to decide what kind of health care services they want and are willing to pay for. [Bill 16-S]

632.88 Policy extension for handicapped children. (1) TERMINATION OF COVERAGE. Every hospital or medical expense insurance policy or contract that provides that coverage of a dependent child of a person insured under the policy shall terminate upon attainment of a limiting age for dependent children specified in the policy shall also provide that the age limitation may not operate to terminate the coverage of a dependent child while the child is and continues to be both:

(a) Incapable of self-sustaining employment because of mental retardation or physical handicap; and

(b) Chiefly dependent upon the person insured under the policy for support and maintenance.

(2) PROOF OF INCAPACITY. The insurer may require that proof of the incapacity and dependency be furnished by the person insured under the policy within 31 days of the date the child attains the limiting age, and at any time thereafter except that the insurer may not require proof more frequently than annually after the 2-year period immediately following attainment of the limiting age by the child.

History: 1975 c. 375.

632.89 Required coverage of alcoholism and other diseases. (1) DEFINITIONS. In this section:

(a) "Outpatient treatment facility" means a facility licensed or approved by the department of health and social services whose outpatient services meet the standards established in s. 51.42 (12) and which provides those services, except inpatient services, enumerated in s. 51.42 (5) (b) to (d) for the prevention and amelioration of mental disabilities, including but not limited to mental and nervous disorders, alcoholism and drug abuse.

(b) "Hospital" is a facility described in s. 50.33 (1) (a) and (c) which is licensed under s. 50.35 or is an approved public or private treatment facility for the treatment of alcoholics as defined in s. 51.45 (2) (b) and (c).

(c) "Physician" has the meaning designated in s. 990.01 (28).

(d) "Outpatient services" means services, medications, equipment and supplies performed or furnished by or under the supervision of or on referral from a physician at a hospital or outpatient treatment facility to a patient who is not a bed patient of the hospital or outpatient treatment facility.

(2) REQUIRED COVERAGE FOR ALL INSURERS UNDER CHAPTERS 611 AND 613. (a) *Scope.* Each group disability policy, joint contract or contract providing hospital treatment coverage shall include coverage for:

1. Inpatient hospital treatment of mental and nervous disorders, alcoholism and drug abuse.

(b) *Exclusions in coverage.* Except as provided in par. (c), coverages under pars. (a) and (d) may not be subject to exclusions or limitations which are not generally applicable to other conditions covered under the policy or contract.

(c) *Minimum confinement.* Coverages under par. (a) 1 may not provide less than 30 days' confinement in any calendar year.

(d) *Outpatient treatment.* Every contract or joint contract issued by an insurer subject to this

section providing coverage for outpatient treatment shall provide coverage for outpatient services for mental and nervous disorders, alcoholism and drug abuse including but not limited to partial hospitalization services, prescribed drugs and collateral interviews with patients' families, relating to diagnosed alcoholism, drug abuse, or mental and nervous disorders of the patient, in an amount not less than the first $500 in any calendar year for any alcoholism or drug abuse services, or for outpatient services provided by or under contract for a board established under s. 51.42, and $500 for any other outpatient services for mental and nervous disorders. No contract or joint contract written in combination with major medical coverage shall be required to provide coverage under this paragraph for more than $500 for any combination of disabilities required to be covered under this paragraph. The department of health and social services may by rule promulgated under ch. 227 adjust this amount at 2-year intervals to reflect changes in the cost of medical care.

(3) ADDITIONAL REQUIRED COVERAGE FOR CORPORATIONS SUBJECT TO CH. 613. Any corporation subject to ch. 613 is subject to sub. (2) and in addition its group disability policies, joint contracts or contracts which provide for hospital treatment or outpatient treatment shall provide:

(a) Outpatient hospital treatment of alcoholism;

(b) Outpatient and home dialysis treatment for kidney disease and kidney transplantation expenses; and

(c) Protection for both recipient and donor of any transplant organs, as provided in s. 49.48 (3) (b).

(4) AMOUNT OF PROTECTION FOR ORGANIZATIONS SUBJECT TO SUB. (3). Coverage under sub. (3) (b) and (c), combined with coverage under s. 632.78 (2), shall not be less than $30,000 annually.

(5) MEDICARE EXCLUSION. No insurer or other organization subject to this section is required to duplicate coverage available under the federal medicare program.

(6) RULES. The department of health and social services may by rule impose reasonable standards for the treatment of kidney diseases required to be covered under this section and s. 632.78 (2), which shall not be inconsistent with or less stringent than applicable federal standards.

History: 1975 c. 223, 224, 375; 1977 c. 203 s. 106.

632.895 Conversion privileges for insured former spouse required. (1) No policy of accident and health insurance providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis, which in addition to covering the insured also provides coverage to the spouse of the insured, may contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship except by reason of an entry of a valid decree of divorce between the parties.

(2) Every such policy which contains a provision for termination of coverage of the spouse upon divorce shall contain a provision to the effect that upon the entry of a valid decree of divorce between the insured parties the divorced spouse shall be entitled to have issued to him or her, without evidence of insurability, upon application made to the company within 60 days following the entry of such decree, and upon the payment of the appropriate premium, an individual policy of accident and health insurance. Such policy shall provide the coverage then being issued by the insurer which is most nearly similar to such terminated coverages. Any and all probationary or waiting periods set forth in such policy shall be considered as being met to the extent coverage was in force under the prior policy.

History: 1977 c. 105.

632.90 Tuberculosis coverage. (1) No policy of disability insurance, whether under subch. II of ch. 40 or otherwise, may include hospital or medical expense coverage unless it contains a provision for a minimum 90 days' continuous coverage of costs for tuberculosis charges, fees or maintenance under ch. 50, including both inpatient care and outpatient dispensary charges or fees. This section applies to all such policies issued, delivered or renewed after August 5, 1973.

(2) The following health or sickness or casualty insurance policies shall not be subject to this section:

(a) Any policy which does not provide hospital expense reimbursement or medical expense reimbursement coverage.

(b) Any policy which only provides benefits for accidental bodily injury, whether or not such policy provides medical services in conjunction with such injury.

(c) Any policy which only provides specific benefits for specific diseases.

History: 1975 c. 223, 289, 375; 1975 c. 422 ss. 105, 145.

Legislative Council Note, 1975: This section continues former s. 204.323. [Bill 17-S]

632.91 Coverage of newborn infants. (1) No policy of disability insurance whether under subch. II of ch. 40, or otherwise, which provides coverage for a member of the insured's family may be issued unless it provides that benefits

applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth.

(2) Coverage for newly born children required under this section shall consider congenital defects and birth abnormalities as an injury or sickness under the policy and shall cover functional repair or restoration of any body part when necessary to achieve normal body functioning, but shall not cover cosmetic surgery performed only to improve appearance.

(3) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy may require that notification of the birth of a child and payment of the required premium or fees shall be furnished to the insurer within 60 days after the date of birth. The insurer may refuse to continue coverage beyond the 60-day period if such notification is not received, unless within one year after the birth of the child the insured makes all past-due payments and in addition pays interest on such payments at the rate of 5 1/2% per annum.

(4) If payment of a specific premium or subscription fee is not required to provide coverage for a child, the policy or contract may request notification of the birth of a child but may not deny or refuse to continue coverage if such notification is not furnished.

(5) This section applies to all policies issued or renewed after May 5, 1976 and to all policies in existence on June 1, 1976. All policies issued or renewed after June 1, 1976 shall be amended to comply with the requirements of this section.

History: 1975 c. 224.

SUBCHAPTER VII

FRATERNAL INSURANCE

632.93 The fraternal contract. (1) ISSUANCE OF CERTIFICATE. A fraternal shall issue to each benefit member a policy or certificate specifying the benefits provided. The policy or certificate, any riders or endorsements attached thereto, the laws of the fraternal, and the application and declarations made in connection therewith and signed by the applicant, constitute the agreement between the fraternal and the member, and the policy or certificate shall so state. A copy of the application and the declarations shall be endorsed upon or attached to the policy or certificate and may not be used in defense against a claim under the policy or certificate unless so endorsed or attached.

(2) REPRESENTATIONS. All statements purporting to be made by the member shall be representations and not warranties. Any waiver of this provision is void and has no effect.

(3) CHANGES IN LAWS OF FRATERNALS. Any changes in the laws of a fraternal made subsequent to the issuance of a policy or certificate bind the member and beneficiary as if they had been in force at the time of the application, so long as they do not destroy or diminish benefits promised in the policy or certificate.

(4) PROOF OF TERMS. Copies of any documents mentioned in subs. (1) to (3), certified by the secretary or corresponding officer of the fraternal, are evidence of the terms and conditions of the contract.

History: 1975 c. 373.

Legislative Council Note, 1975: Sub. (1) continues, with much editing and some substantial changes, former s. 208.16 (1); subs. (2), (3) and (4) do the same for s. 208.16 (2), (3) and (4), respectively. [Bill 643-S]

632.94 Contents of the fraternal contract. (1) DEFINITION. In this section "certificate" means the document specifying the benefits provided for by the contract or policy together with any riders or endorsements attached thereto.

(2) LIFE INSURANCE CONTRACTS, PROHIBITED PROVISIONS. On and after January 1, 1966, no certificate of life insurance may be delivered or issued for delivery in this state containing in substance any of the following provisions:

(a) Any provision limiting the time within which any action at law or in equity may be commenced to less than 2 years after the cause of action accrues;

(b) Any provision by which the certificate purports to be issued or to take effect more than 6 months before the original application for the certificate was made, except in case of transfer from one form of certificate to another in connection with which the member is to receive credit for any reserve accumulation under the form of certificate from which the transfer is made; or

(c) Any provision for forfeiture of the certificate for failure to repay any loan thereon or to pay interest on such loan while the total indebtedness, including interest, is less than the loan value of the certificate.

(3) LIFE INSURANCE CONTRACTS, REQUIRED PROVISIONS. On and after January 1, 1966, no certificate of life insurance may be delivered or issued for delivery in this state unless a copy of the form has been filed with and approved by the commissioner. This certificate shall contain in substance the following standard provisions or, in lieu thereof, provisions which are more favorable to the member:

(a) Title on the face and filing page of the certificate clearly and correctly describing its form;

(b) A provision stating the amount of rates, premiums or other required contributions, by

whatever name known, which are payable by the insured under the certificate;

(c) A provision that the member is entitled to a grace period of not less than a full month (or 30 days at the option of the fraternal) in which the payment of any premium after the first, may be made. During such grace period the certificate shall continue in full force, but in case the certificate becomes a claim during the grace period before the overdue payment is made, the amount of such overdue payments may be deducted in any settlement under the certificate;

(d) A provision that the member shall be entitled to have the certificate reinstated at any time within 3 years from the due date of the premium in default, unless the certificate has been completely terminated through the application of a nonforfeiture benefit, cash surrender value or certificate loan, upon the production of evidence of insurability satisfactory to the fraternal and the payment of all overdue premiums and any other indebtedness to the fraternal upon the certificate, together with interest on such premiums and such indebtedness, if any, at a rate not exceeding 6% per annum compounded annually;

(e) Except in the case of pure endowment, annuity or reversionary annuity contracts, reducing term insurance contracts, or contracts of term insurance of uniform amount of 15 years or less expiring before age 66 a provision that, in the event of default in payment of any premium after 3 full years' premiums have been paid or after premiums for a lesser period have been paid if the contract so provides, the fraternal will grant, upon proper request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on the plan stipulated in the certificate, effective as of such due date, of the value specified in s. 632.43. The certificate may provide, if the fraternal's laws so specify or if the member so elects prior to the expiration of the grace period of any overdue premium, that default shall not occur so long as premiums can be paid under the provisions of an arrangement for automatic premium loan as may be set forth in the certificate;

(f) A provision that one paid-up nonforfeiture benefit as specified in the certificate shall become effective automatically unless the member elects another available paid-up nonforfeiture benefit, not later than 60 days after the due date of the premium in default;

(g) A statement of the mortality table and rate of interest used in determining all paid-up nonforfeiture benefits and cash surrender options available under the certificate, and a brief general statement of the method used in calculating such benefits;

(h) A table showing in figures the value of every paid-up nonforfeiture benefit and cash surrender option available under the certificate for each certificate anniversary either during the first 20 certificate years or during the term of the certificate whichever is shorter;

(i) A provision that the certificate shall be incontestable after it has been in force during the lifetime of the member for a period of 2 years from its date of issue except for nonpayment of premiums, violation of the provisions of the certificate relating to military, aviation, or naval service and violation of the provisions relating to suspension or expulsion as substantially set forth in the certificate. At the option of the fraternal, supplemental provisions relating to benefits in the event of temporary or permanent disability or hospitalization and provisions which grant additional insurance specifically against death by accident or accidental means, may also be excepted. The certificate shall be incontestable on the ground of suicide after it has been in force during the lifetime of the member for a period of 2 years from date of issue. The certificate may provide, as to statements made to procure a reinstatement, that the fraternal shall have the right to contest a reinstated certificate within a period of 2 years from date of reinstatement with the same exceptions as herein provided;

(j) A provision that in case of age or sex of the member or of any other person is considered in determining the premium and it is found at any time before final settlement under the certificate that the age or sex has been misstated, and the discrepancy and premium involved have not been adjusted, the amount payable shall be such as the premium would have purchased at the correct age and sex; but if the correct age or sex was not an insurable age or sex under the fraternal's charter or laws, only the premiums paid to the fraternal, less any payments previously made to the member, shall be returned or, at the option of the fraternal, the amount payable under the certificate shall be such as the premium would have purchased at the correct age and sex according to the fraternal's promulgated rates and any extension thereof based on actuarial principles;

(k) A provision or provisions which recite fully, or which set forth the substance of, all sections of the charter, constitution, laws, rules or regulations of the fraternal, in force at the time of issuance of the certificate, the violation of which will result in the termination of, or in the reduction of, the benefit or benefits payable under the certificate; and

(l) If the constitution or laws of the fraternal provide for expulsion or suspension of a member, a provision that any member so expelled or suspended, except for nonpayment of a premium

or within the contestable period for material misrepresentations in such member's application for membership shall have the privilege of maintaining such member's insurance in force by continuing payment of the required premium.

(m) Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance or because the certificate is an annuity certificate may, to the extent inapplicable, be omitted from the certificate.

(4) DISABILITY CONTRACTS. No domestic or nondomestic fraternal authorized to do business in this state may issue or deliver in this state any certificate of accident insurance or health insurance or of any total and permanent disability insurance contract unless and until the form has been filed with and approved by the commissioner.

History: 1975 c. 373 ss. 15 to 18, 34, 39; 1975 c. 421; 1977 c. 153 s. 6; 1977 c. 339 s. 44.

Legislative Council Note, 1975: These provisions carry forward, slightly edited to conform to the new terminology adopted by this code, ss. 208.161 and 208.162 dealing with required and prohibited provisions in life insurance and disability insurance contracts. "Certificate" has been defined for the purpose of this section to carry out the meaning commonly used by the fraternals and to distinguish it from the general use throughout this code as referring to individual contracts under a group insurance policy.

No substantive changes have been made. Therefore, the grace period remains at 30 days in contrast to the 31-day period for life insurance generally and the effect of misstatement is tied to both age and sex in contrast to the limitation of misstatement to age only for life insurance generally (s. 632.46 (3)).

The definition of "premium" in s. 208.161 (3) is no longer necessary because of the general definition contained in s. 600.03 (38). [Bill 643-S]

632.95 Fraud in obtaining membership. Subject to s. 632.46, any certificate of membership secured by misrepresentation in or with reference to any application for membership or documentary or other proof for the purpose of obtaining membership in or noninsurance benefit from the fraternal is void, if the fraternal relied on it and it is either material or fraudulent.

History: 1975 c. 373.

Legislative Council Note, 1975: This section continues the contractual portion of s. 208.38, edited with a change in meaning, to include nonfraudulent but material misrepresentation, and also to subject the provision to the rule of incontestability provided in s. 632.46. [Bill 643-S]

632.96 Beneficiaries in fraternal contracts. (1) Any member may designate as beneficiary any person permitted by the laws of the fraternal. Those laws shall authorize the designation of the member's estate as beneficiary.

(2) Subject to sub. (1), s. 632.48 applies.

History: 1975 c. 373, 421.

Legislative Council Note, 1975: Sub. (1) states a rule slightly more restrictive of the range of permitted beneficiaries than for commercial life insurance; this reflects the nature of the fraternal. Sub. (2) applies the general provision for life insurance, subject to sub. (1). [Bill 643-S]

SUBCHAPTER VIII

MISCELLANEOUS

632.97 Application of proceeds of credit insurance policy. Payment to a creditor of any amounts insured under the terms of a credit insurance policy reduces the debt proportionately. This rule does not apply to an insurance policy on which the debtor pays no part of the premium, directly or indirectly.

History: 1975 c. 375.

632.98 Worker's compensation insurance contract provisions. Section 102.31 applies to worker's compensation insurance.

History: 1975 c. 375, 421.