CHAPTER 632

INSURANCE CONTRACTS IN SPECIFIC LINES

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.

SUBCHAPTER I

FIRE AND OTHER PROPERTY INSURANCE

632.05 Indemnity amounts. (1) 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.

(2) TOTAL LOSS. Whenever any policy insures real property which is owned and occupied by the insured as a dwelling and the property is wholly destroyed, without criminal fault on the part of the insured or the insured's assigns, the amount of the loss shall be taken conclusively to be the policy limits of the policy insuring the property.

History: 1975 c. 375; 1979 c. 73, 177.

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 insurance covers real property, any loss not exceeding $500 shall be paid to the insured mortgagor despite the provision, unless the mortgagee is a named insured.

History: 1975 c. 375; 1979 c. 102.

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.

Federal compulsory counterclaim rule precluded action against insurer under state direct action statute where action directly against insured was barred by rule. Fagnan v. Great Central Ins. Co. 577 F (2d) 418 (1978).

Breach of fiduciary duty was negligence for purposes of Wisconsin's direct action and direct liability statutes. Federal Deposit Ins. Co. v. MGIC Indem. Corp. 462 F Supp. 759 (1978).

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.

"Condition" as used in this section does not refer to exclusion. Bortz v. Merrimac Mutual Ins. Co. 92 W (2d) 865, 286 NW (2d) 16 (Ct. App. 1979).

632.26 Notice provisions. (1) REQUIRED PROVISIONS. Every liability insurance policy shall provide:

(a) 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.

(b) That failure to give any notice required by the policy within the time specified does not invalidate a claim made by the insured if the insured shows that it was not reasonably possible to give the notice within the prescribed time and that notice was given as soon as reasonably possible.

(2) EFFECT OF FAILURE TO GIVE NOTICE. Failure to give notice as required by the policy as modified by sub. (1) (b) does not bar liability under the policy if the insurer was not prejudiced by the failure, but the risk of nonpersuasion is upon the person claiming there was no prejudice.

History: 1979 c. 102.

Legislative Council Note, 1979: Subsection (1) is former s. 632.32 (1), altered in 2 ways: (1) to extend its coverage to all liability policies; and (2) to change "may" to "shall". The subsection is divided into 2 paragraphs for clarity.

The first change would strengthen the law. It is entirely new and seems a desirable extension.

The second change corrects an error. The word "shall" was used in the fourth draft of the bill that ultimately became ch. 375, laws of 1975, and was not changed in the addendum to the fourth draft, dated July 14, 1975. Those documents went to the insurance laws revision committee and then to the legislative council for action. Nothing appears in the minutes of the committee's meeting of July 14, 1975 to indicate that a change was made. But in LRB-6218/1 of 1975, "may" appears instead of "shall". That error, which was probably inadvertent and the source of which we have not been able to trace, was carried on into the final enactment.

Sub. (2) continues the second sentence of former s. 632.34 (4). Shifting it to s. 632.26, which is applicable to all liability insurance, broadens its application, but that seems desirable. The term "burden of proof" is changed to "risk of nonpersuasion" to tighten up the meaning. "Burden of proof" is a broad term that comprehends 2 separate concepts: (1) the burden of going forward with the evidence and (2) the burden of persuading the trier of fact, better termed the "risk of nonpersuasion". See McCormick, Evidence, (2nd ed.), at 784 n. 4 (1972). The statute is concerned with determining who wins when the totality of evidence is inconclusive, not with the burden of going forward, which ought to be settled on the basis of general principles. Indeed, since the insurer will have best (or the only) access to information about prejudice, it may be quite unfair to put the burden of going forward on the claimant.

Subs. (1) (b) and (2) are related. The first is a required provision in the policy. The 2nd is a rule of law. It is preferable not to go too far in inserting excuses into the policy. Sub. (1) (b) encourages the insured not to give up automatically if notice is not timely given, but insertion of sub. (2) into the policy would arguably encourage an unduly long delay that might prejudice both parties. [Bill 146-S]

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

SUBCHAPTER IV

AUTOMOBILE AND MOTOR VEHICLE INSURANCE

632.32 Provisions of motor vehicle insurance policies. (1) SCOPE. Except as otherwise provided, this section applies to every policy of insurance issued or delivered in this state against the insured's liability for loss or damage resulting from accident caused by any motor vehicle, whether the loss or damage is to property or to a person.

(2) DEFINITIONS. In this section:

(a) "Motor vehicle" means a self-propelled land motor vehicle designed for travel on public roads and subject to motor vehicle registration under ch. 341. It includes trailers and semitrailers designed for use with such vehicles. It does not include farm tractors, well drillers, road machinery or snowmobiles.

(b) "Motor vehicle handler" means a motor vehicle sales agency, repair shop, service station, storage garage or public parking place.

(c) "Using" includes driving, operating, manipulating, riding in and any other use.

(3) REQUIRED PROVISIONS. Except as provided in sub. (5), every policy subject to this section issued to an owner shall provide that:

(a) Coverage provided to the named insured applies in the same manner and under the same provisions to any person using any motor vehicle described in the policy when the use is for purposes and in the manner described in the policy.

(b) Coverage extends to any person legally responsible for the use of the motor vehicle.

(4) REQUIRED UNINSURED MOTORIST AND MEDICAL PAYMENTS COVERAGES. Every policy of insurance subject to this section that insures with respect to any motor vehicle registered or principally garaged in this state against loss resulting from liability imposed by law for bodily injury or death suffered by any person arising out of the ownership, maintenance or use of a motor vehicle shall contain therein or supplemental thereto provisions approved by the commissioner:

(a) *Uninsured motorist.* 1. 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, in limits of at least $15,000 per person and $30,000 per accident. The insurer may increase the coverage limits provided under this paragraph up to the bodily injury liability limits provided in the policy.

2. In this paragraph "uninsured motor vehicle" also includes:

a. 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.

b. An unidentified motor vehicle involved in a hit-and-run accident.

3. Insurers making payment under the uninsured motorists' coverage shall, to the extent of the payment, be subrogated to the rights of their insureds.

(b) *Medical payments.* To indemnify for medical payments or chiropractic payments or both in the amount of at least $1,000 per person for protection of all persons using the insured motor 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. Coverage written under this paragraph may be excess coverage over any other source of reimbursement to which the insured person has a legal right.

(5) PERMISSIBLE PROVISIONS. (a) A policy may limit coverage to use that is with the permission of the named insured or, if the insured is an individual, to use that is with the permission of the named insured or an adult

member of that insured's household other than a chauffeur or domestic servant. The permission is effective even if it violates s. 343.45 (2) and even if the use is not authorized by law.

(b) If the policy is issued to anyone other than a motor vehicle handler, it may limit the coverage afforded to a motor vehicle handler or its officers, agents or employes to the limits under s. 344.01 (2) (d) and to instances when there is no other valid and collectible insurance with at least those limits whether the other insurance is primary, excess or contingent.

(c) If the policy is issued to a motor vehicle handler, it may restrict coverage afforded to anyone other than the motor vehicle handler or its officers, agents or employes to the limits under s. 344.01 (2) (d) and to instances when there is no other valid and collectible insurance with at least those limits whether the other insurance is primary, excess or contingent.

(d) If a motor vehicle covered by the policy is sold or transferred, the purchaser or transferee is not an additional insured unless the consent of the insurer is endorsed on the policy.

(e) A policy may provide for exclusions not prohibited by sub. (6) or other applicable law. Such exclusions are effective even if incidentally to their main purpose they exclude persons, uses or coverages that could not be directly excluded under sub. (6) (b).

(6) PROHIBITED PROVISIONS. (a) No policy issued to a motor vehicle handler may exclude coverage upon any of its officers, agents or employes when any of them are using motor vehicles owned by customers doing business with the motor vehicle handler.

(b) No policy may exclude from the coverage afforded or benefits provided:

1. Persons related by blood or marriage to the insured.

2. a. Any person who is a named insured or passenger in or on the insured vehicle, with respect to bodily injury, sickness or disease, including death resulting therefrom, to that person.

b. This subdivision, as it relates to passengers, does not apply to a policy of insurance for a motor-driven cycle as defined in s. 340.01 (33) or a moped as defined in s. 340.01 (29m) if the motor-driven cycle or moped is designed to carry only one person and does not have a seat for any passenger.

3. Any person while using the motor vehicle, solely for reasons of age, if the person is of an age authorized to drive a motor vehicle.

4. Any use of the motor vehicle for unlawful purposes, or for transportation of liquor in violation of law, or while the driver is under the influence of intoxicating liquors or narcotics or any use of the motor vehicle in a reckless manner.

(c) No policy may limit the time for giving notice of any accident or casualty covered by the policy to less than 20 days.

(7) RIDE-SHARING. No insurer may increase the premium charged for a motor vehicle insurance policy delivered or issued in this state based on the fact that a motor vehicle covered by the policy is used for ride-sharing. The commissioner shall enforce this subsection under ss. 601.41 and 601.64.

History: 1975 c. 375, 421; 1979 c. 102, 104; 1979 c. 177 ss. 67, 68; 1979 c. 221.

NOTE: Sub. (7) is repealed effective May 1, 1982.

Legislative Council Note, 1979: Sub. (1) retains the scope portion of former sub. (1), but the notice provision of former sub. (1) is transferred to new s. 632.26 and broadened to apply to all liability insurance.

Sub. (2) (b) continues former sub. (2) (a); pars. (a) and (c) are new definitions in this place, though par. (a) tracks the language of s. 344.01 (2) (b). It would be possible to sharpen up the definition of motor vehicle, though that can only be done on the basis of a policy determination of what policies should be subject to this section. The exact delimitation of the affected class of policies is of less importance than if the section were mandating insurance or purported to change rules of law.

Sub. (4) continues former sub. (3) and former s. 632.34 (5) with major editorial changes but without intended change of meaning except to add an unidentified hit-run vehicle as an uninsured vehicle. A precise definition of hit-and-run is not necessary for in the rare case where a question arises the court can draw the line.

Sub. (5) continues the permitted provisions of former sub. (2) (b). Par. (d) continues a sentence of former s. 632.32 (2) (b), relocated in relation to other provisions to make its application clearer.

Sub. (5) (e) deals with a latent ambiguity in former s. 204.34, carried forward into s. 632.34, which was picked up and noticed by the Wisconsin Supreme Court in Davison v. Wilson (1975), 71 Wis. 2d 630. The court suggested (at p. 641) that the section should be the subject of a clarifying amendment. The same ambiguity was dealt with by the court in Dahm v. Employers Mutual Liability Insurance Company of Wisconsin (1976), 74 Wis. 2d 123. The resolution of the ambiguity in par. (e) is believed to represent the probable intention of the legislature in the original enactment and, in any event, to represent the sound position in public policy.

Sub. (6) deals with prohibited provisions. Par. (a) picks up the last sentence of former sub. (2) (b) which was a prohibited rather than a required provision. Par. (b) incorporates what was formerly s. 632.34 (3) in sub. (6) (b) 1, former subs. (5) and (6) in sub. (6) (b) 2, former sub. (2) (a) in sub. (6) (b) 3 and former sub. (2) (b) and (c) in sub. (6) (b) 4. Par. (c) continues the first sentence of former s. 632.34 (4), without change.

It escaped the attention of everyone involved in the revision, and not least the principal drafters, that former s. 632.34 (1) narrowed the coverage of old s. 204.34. That has led, in this amendment, to combining most of ss. 632.32 and 632.34 in a single section, numbered 632.32. All parts of s. 632.34 which need to be preserved are transferred to s. 632.32, with the minor exception contained in new s. 632.34. [Bill 146-S]

"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.

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

Fellow employe exclusion clause is only valid where tort feasor 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.

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.

Implied permission of named insured discussed. American Family Mut. Ins. Co. v. Osusky, 90 W (2d) 142, 279 NW (2d) 719 (Ct. App. 1979).

Mandatory coverage provisions of uninsured motorist statute (204.30 (5) (a), 1973 Stats.) were violated by policy exclusion that denied coverage to insured injured by uninsured motorist while insured was occupying uninsured vehicle owned by named insured. Roe v. Larson, 94 W (2d) 204, 287 NW (2d) 824 (Ct. App. 1979).

Injury to police officer who was stabbed while unloading beer cans from automobile did not arise out of use of automobile. Tomlin v. State Farm Mut. Auto. Ins. Co. 95 W (2d) 215, 290 NW (2d) 285 (1980).

632.34 Defense of noncooperation. If a policy of automobile liability insurance provides a defense to the insurer for lack of cooperation on the part of the insured, 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, after payment the insurer is subrogated to the injured person's claim against the insured to the extent of the payment and is entitled to reimbursement by the insured.

History: 1975 c. 375, 421; 1979 c. 102, 104, 177.

Legislative Council Note, 1979: This provision is continued from former s. 632.34 (8). It is changed from a required provision of the policy to a rule of law. It is not the kind of rule that needs to be put in the policy to inform the policyholder. Indeed, the policyholder should receive no encouragement to fail to cooperate. This is a relaxation of present law. [Bill 146-S]

632.35 Prohibited rejection, cancellation and nonrenewal. No insurer may cancel or refuse to issue or renew an automobile insurance policy wholly or partially because of one or more of the following characteristics of any person: age, sex, residence, race, color, creed, religion, national origin, ancestry, marital status or occupation.

History: 1975 c. 375; 1979 c. 102.

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 or other disposition of the body of a deceased may provide that the benefits are payable to a funeral director or any other person doing business related to burials.

History: 1975 c. 373, 375, 422; 1979 c. 102.

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 sub. (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 sub. (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 subs. (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 sub. (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 year, 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 year, 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 year, 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 year 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 subs. (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; 1979 c. 110 s. 60 (13).

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 year 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 year 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; 1979 c. 110 s. 60 (13).

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 chs. 600 to 646 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 and a grace provision appropriate to such a contract in lieu of the provision required by s. 632.44. 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; 1979 c. 89, 102, 177.

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 OR SEX. (a) Subject to par. (b), if the age or sex 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 or sex 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; 1979 c. 102

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, but formalities prescribed under this subsection shall be designed only for the protection of the insurer. 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 under sub. (1) (b). It has actual notice if the prescribed formalities are complied with or if the change in beneficiary has been requested in the form prescribed by the insurer and delivered to an intermediary representing the insurer.

History: 1975 c. 373, 375, 422; 1979 c. 93

Legislative Council Note, 1979: The amendment to sub. (2) adds a situation in which the insured has acted reasonably in dealing with a representative of the insurer. As between the insurer and the insured, the burden should fall upon the insurer if the agent makes an error of this kind. The insurer, of course, may have a cause of action against its agent. [Bill 20-S]

632.49 Death presumed from absence. Sections 813.22 to 813.34 apply to all life insurance policies.

History: 1979 c. 102 s. 174.

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 proportional premium for the time the policy was in force during the grace period.

History: 1975 c. 375, 421; 1979 c. 110 s. 60 (11).

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 chs. 600 to 646 authorizes licensees under s. 138.09 to require or accept insurance not permitted under s. 138.09 (7) (h).

History: 1975 c. 375; 1979 c. 89.

632.62 Participating and nonparticipating policies. (1) AUTHORIZATION. (a) *Stock insurers.* A stock insurer may issue both participating and nonparticipating life insurance policies and annuity contracts, 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; 1979 c. 102.

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.

(3) PROHIBITION OF EXCLUSION FROM COVERAGE OF CERTAIN DEPENDENT CHILDREN. No disability insurance policy issued or renewed on or after April 30, 1980 may exclude or terminate from coverage any dependent child of an insured person or group member solely because the child does not reside with the insured person or group member.

History: 1975 c. 375; 1979 c. 221.

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 from the date of change of occupation or the last policy anniversary date, whichever is the more recent, 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; 1979 c. 102.

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 proportional 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.

(4) SKILLED NURSING CARE. (a) Except as provided in par. (b), every disability insurance policy filed after November 29, 1979, which provides coverage for hospital care shall provide coverage for at least 30 days for skilled nursing care to patients who enter a licensed skilled nursing care facility within 24 hours after discharge from a general hospital. The daily rate payable under this subsection shall not exceed the maximum daily rate established for licensed skilled nursing care facilities by the department of health and social services. The coverage under this subsection shall apply only to skilled nursing care which is certified as medically necessary by the attending physician and is recertified as medically necessary every 7 days. The coverage under this subsection shall apply only to the continued treatment for the same medical or surgical condition for which the insured had been treated at the hospital prior to entry into the skilled nursing care facility. The coverage under this subsection shall not apply to care which is essentially domiciliary or custodial, or to care which is available to the insured without charge or under a governmental health care program, other than a program provided under s. 49.46 or 49.47.

(b) Paragraph (a) does not apply to any policy which provides benefits in a stated amount for confinement in a hospital, regardless of the hospital expenses actually incurred as a result of confinement in the hospital.

History: 1975 c. 375; 1977 c. 371; 1979 c. 75; 1979 c. 110 s. 60 (11); 1979 c. 221.

632.785 Notice of mandatory risk sharing plan. (1) If an insurer issues one or more of the following or takes any other action based wholly or partially on medical underwriting considerations which is likely to render any person eligible under s. 619.12 for coverage under subch. II of ch. 619, the insurer shall notify all persons covered or to be covered by the policy of the existence of the mandatory health insurance risk sharing plan under subch. II of ch. 619, as well as the eligibility requirements and method of applying for coverage under the plan:

(a) A notice of rejection or cancellation of coverage.

(b) A notice of reduction or limitation of coverage, including restrictive riders, if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a person considered a standard risk for the type of coverage provided by the plan.

(c) A notice of increase in premium exceeding the premium then in effect for the insured person by 50% or more, unless the increase applies to substantially all of the insurer's health insurance policies then in effect.

(d) A notice of premium for a policy not yet in effect which exceeds the premium applicable to a person considered a standard risk by 50% or more for the types of coverage provided by the plan.

(2) Any notice issued under sub. (1) shall also state the reasons for the rejection, termination, cancellation or imposition of underwriting restrictions.

History: 1979 c. 313.

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 s. 185.981 or by any insurer authorized under chs. 600 to 646 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), the administrator responsible for determining the persons covered and the premiums payable to the insurer or organization under any group policy or plan of disability insurance is responsible for providing such notices.

(3) 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.

(5) 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; 1979 c. 32, 221.

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. (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.* 1. 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.

2. On or after January 1, 1981, no contract issued or renewed by an insurer may limit insurance coverage of any service provided by a state or county owned or operated inpatient health care facility, as defined in s. 140.85 (1), unless the contract similarly limits coverage of the service if provided by any other inpatient health care facility.

(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.

(2m) LIABILITY TO THE STATE OR COUNTY. For any insurance policy issued on or after January 1, 1981, any insurer providing hospital treatment coverage is liable to the state or county for any costs incurred for services a state or county owned or operated inpatient health care facility, as defined in s. 140.85 (1), provides to a patient regardless of the patient's liability for the services, to the extent that the insurer is liable to the patient for services provided at any other inpatient health care facility.

(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; 1979 c. 175, 221.

632.897 Hospital and medical coverage for persons insured under individual and group policies. (1) In this section:

(a) "Dependent" means a person who is or would be covered as a dependent of a group member under the terms of the group policy including, but not limited to, age limits, if the group member continues or had continued as a member of the group.

(b) "Employer" means the policyholder in the case of a group policy as defined in par. (c) 1 and the sponsor in the case of a group policy as defined in par. (c) 2 or 3.

(c) "Group policy" means:

1. An insurance policy issued by an insurer to a policyholder on behalf of a group whose members thereby receive hospital or medical coverage on either an expense incurred or service basis, other than for specified diseases or for accidental injuries;

2. An uninsured plan or program whereby a health maintenance organization, labor union, religious community or other sponsor contracts to provide hospital or medical coverage to members of a group on either an expense incurred or service basis, other than for specified diseases or for accidental injuries; or

3. A plan or program whereby a sponsor arranges for the mass marketing of franchise insurance to members of a group related to one another through their relationship with the sponsor.

(cm) "Individual policy" means an insurance policy whereby an insured receives hospital or medical coverage on either an expense incurred or service basis, other than for specified diseases or for accidental injuries.

(d) "Insurer" means the insurer in the case of a group policy as defined in par. (c) 1 or 3 and the sponsor in the case of a group policy as defined in par. (c) 2.

(e) "Medicare" means coverage under both part A and part B of Title XVIII of the federal social security act, 42 USC 1395 et seq., as amended.

(f) "Terminated insured" means a person entitled to elect continued or conversion coverage under sub. (2) (b) or (9).

(2) (a) No group policy which provides coverage to the spouse of the group member may contain a provision for termination of coverage for the spouse solely as a result of a break in their marital relationship except by reason of the entry of a judgment of divorce or annulment of their marriage.

(b) An insurer issuing or renewing a group policy on or after May 14, 1980 and every insurer on and after the date which is 2 years after May 14, 1980 shall permit the following persons who have been continuously covered under a group policy for at least 3 months to elect to continue group policy coverage under sub. (3) or to convert to individual coverage under sub. (4):

1. The former spouse of a group member who otherwise would terminate coverage because of divorce or annulment.

2. A group member who would otherwise terminate eligibility for coverage under the group policy other than a group member who terminates eligibility for coverage due to discharge for misconduct shown in connection with his or her employment.

3. The spouse or dependent of a group member if the group member dies while covered by the group policy and the spouse or dependent was also covered.

(c) Group policy coverage of a terminated insured who is entitled under par. (b) to elect continued group policy coverage or conversion to individual coverage and coverage of the spouse and dependents of the terminated insured provided for in the group policy continues until the terminated insured is notified under par. (d) of the right to elect continued or conversion coverage if the premium for the coverage continues to be paid.

(d) If the employer is notified to terminate the coverage for any of the reasons provided under par. (b), the employer shall provide the terminated insured written notification of the right to continue group coverage or convert to individual coverage and the payment amounts required for either continued or converted coverage including the manner, place and time in which the payments shall be made. This notice shall be given not less than 5 days after the employer receives notice to terminate coverage. The payment amount for continued group coverage may not exceed the group rate in effect for a group member, including an employer's contribution, if any, for a group policy as defined in sub. (1) (c) 1 or the equivalent value of the monthly contribution of a group member to a group policy as defined in sub. (1) (c) 2 or the equivalent value of the monthly premium for franchise insurance as defined in sub. (1) (c) 3. The premium for converted coverage shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risks of each person to be covered under that policy and to the type and amount of coverage provided. The notice may be sent to the terminated insured's home address as shown on the records of the employer.

(3) (a) If the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured, elects to continue group coverage and tenders to the employer the

amount required within 30 days after receiving notice under sub. (2) (d), coverage of the terminated insured and, if the terminated insured is eligible for continued coverage under sub. (2) (b) 2, coverage of the covered spouse and dependents of the terminated insured shall continue without interruption and may not terminate unless one of the following occurs:

1. The terminated insured establishes residence outside this state.

2. The terminated insured fails to make timely payment of a required premium amount.

3. The terminated insured is eligible for continued coverage under sub. (2) (b) 1 and the group member through whom the former spouse originally obtained coverage is no longer eligible for coverage by the group policy.

4. The terminated insured becomes eligible for similar coverage under another group policy.

(b) If the coverage of the terminated insured is terminated under par. (a) 3 and the group member through whom the terminated insured originally obtained coverage becomes eligible for coverage by a replacement group policy providing coverage to the same group, the former spouse shall have the right to coverage by the replacement group policy as provided in this subsection.

(c) If the right of the terminated insured to continue group policy coverage is terminated under par. (a) 3 and the group member does not become eligible for coverage by a replacement group policy, the terminated insured has the right to convert to individual coverage under sub. (4), unless sub. (4) (d) applies.

(d) If the right of the terminated insured to continue group policy coverage is terminated under par. (a) 1 the terminated insured, and a spouse or dependent of the terminated insured, if the terminated insured was eligible for continued group coverage under sub. (2) (b) 2 and the spouse or dependent was covered under the group policy, have the right to convert to individual coverage under sub. (4), unless sub. (4) (d) applies.

(e) This subsection does not require coverage of expenses which are covered by medicare.

(4) (a) A terminated insured who elects conversion coverage under sub. (2) (b) or (3) (c) or (d), the spouse or dependent of such a terminated insured, if the terminated insured is eligible under sub. (2) (b) 2 and the spouse or dependent was covered under the group policy, and a terminated insured eligible under sub. (9) and his or her dependents are entitled to have the insurer issue to them, without evidence of insurability, individual coverage reasonably similar to the terminated coverage under the group policy or individual policy. Any probationary or waiting periods required by such individual coverage shall be considered as being met to the extent such limitations have been met under the prior group policy or individual policy.

(b) The commissioner of insurance shall promulgate, by rule, 3 plans of individual coverage varying in degree of covered benefits to be offered as individual conversion policies. The insurer provides reasonably similar individual coverage if a person is offered his or her choice of the plans promulgated by the commissioner of insurance or is offered a high limit comprehensive plan of benefits regularly provided by the insurer for conversions and approved for this purpose by the commissioner of insurance.

(c) If the first premium for conversion coverage is tendered to the insurer within 30 days after the notice of termination of group coverage, the individual conversion policy shall be issued with an effective date of the day following the termination of group or individual coverage.

(d) This subsection does not require individual coverage to be offered by an insurer offering group policies only. This subsection does not require an insurer to issue, or continue in force, an individual conversion policy covering a terminated insured or his or her spouse or dependent if benefits provided or available to the covered person under subds. 1 to 3, together with the converted policy's benefits, would result in overinsurance according to the insurer's standards for overinsurance, and these standards have been filed with and approved by the commissioner prior to use:

1. Similar benefits under another individual policy for which the terminated insured, spouse or dependent is eligible.

2. Similar benefits under a group policy for which the terminated insured, spouse or dependent is eligible.

3. Similar benefits for which the terminated insured, spouse or dependent is eligible by reason of any state or federal law.

(5) A notification of the group continuation and individual conversion privileges shall be included in each certificate of coverage for a group policy as defined in sub. (1) (c) 1 or 3 and in any evidence of coverage provided by a group policy as defined in sub. (1) (c) 2.

(6) If the terminated insured elects to continue group coverage as provided in this section, the insurer may require conversion to individual coverage by the terminated insured and his or her spouse and dependents 12 months after the terminated insured elects the group coverage. The conditions, rights and procedures governing conversion under sub. (4) (a) apply to this conversion.

(7) No group policy which provides coverage to children of group members may deny eligibility for coverage to a child solely because the child does not reside with the group member or solely because the child is dependent on a former spouse of the group member rather than on the group member. A child of dependent age, as defined by the group policy, who does not reside with the group member or who is dependent on a former spouse may be excluded from coverage according to the same criteria used to determine exclusion from coverage of a child who resides with and is dependent on the group member.

(8) Premium payments for continued group coverage required under this section shall be paid to the employer. The employer shall collect, and the insurer shall bill the employer for, those premiums. The insurer shall charge the claims experience of individuals covered under continued group coverage against the claims experience of the employer. An insurer is not required to issue a new certificate of insurance to an individual obtaining continued group coverage under this section.

(9) (a) No individual policy which provides coverage to the spouse of the insured may contain a provision for termination of coverage for the spouse solely as a result of a break in their marital relationship except by reason of the entry of a judgment of divorce or annulment of their marriage.

(b) Every individual policy which contains a provision for the termination of coverage of the spouse of the insured upon divorce or annulment shall contain a provision to the effect that upon divorce or annulment the former spouse has the right to obtain individual coverage under sub. (4) and that coverage of the former spouse shall continue until he or she is notified of that right in accordance with par. (c) if the premium for the coverage continues to be paid by or on behalf of the former spouse. This individual coverage shall provide to the former spouse the option to include dependent children previously covered.

(c) When the insurer is notified that the coverage of a spouse may be terminated because of a divorce or annulment, the insurer shall provide the former spouse written notification of the right to obtain individual coverage under sub. (4), the premium amounts required and the manner, place and time in which premiums may be paid. This notice shall be given not less than 30 days before the former spouse's coverage would otherwise terminate. The premium shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of every person to be covered and to the type and amount of coverage provided. If the former spouse tenders the first monthly premium to the insurer within 30 days after the notice provided by this paragraph, sub. (4) shall apply and the former spouse shall receive individual coverage commencing immediately upon termination of his or her coverage under the insured's policy.

(10) No group policy or individual policy which provides coverage to dependent children of the group member or insured may deny eligibility for coverage to any child solely because the child does not reside with the group member or insured or solely because the child is dependent on a former spouse rather than the group member or insured. A child of dependent age, as defined by the group policy or individual policy, who does not reside with the group member or insured, or who is dependent on a former spouse, may be excluded from coverage according to the same criteria used to determine exclusion from coverage of a child who resides with and is dependent on the group member or insured.

History: 1979 c. 285, 355.

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 year.

(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; 1979 c. 110 s. 60 (13).

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 and containing at least in substance all sections of the laws of the fraternal which might result in the termination of coverage or the reduction of benefits. 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.

(2) 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.

(3) PROOF OF TERMS. Copies of any documents mentioned in subs. (1) and (2), certified by the secretary or corresponding officer of the fraternal, are evidence of the terms and conditions of the contract.

(4) INAPPLICABLE PROVISIONS. Sections 631.13 and 632.44 (2) do not apply to fraternal contracts.

(5) GRACE PERIOD. Every fraternal certificate shall contain a provision entitling the member to a grace period of not less than one month, or 30 days at the fraternal's option, for the payment of any premium due except the first, during which the death benefit shall continue in force. A fraternal may specify in the grace period provision that the overdue premium will be deducted from the death benefit in the event of death before it is paid.

(6) COMPLIANCE WITH OTHER PROVISIONS. If a fraternal's laws provide for expulsion or suspension of a member for any reason other than nonpayment of premium or under s. 632.46, the fraternal's insurance certificate shall contain a provision that if a member is expelled or suspended for any reason other than nonpayment of premium or under s. 632.46, the expelled member has the right to maintain the policy in force by continuing payment of the required premium.

(7) SCOPE OF APPLICATION. This section applies to all contracts made by a fraternal beginning 6 months after December 18, 1979. A fraternal may elect to have this section apply at an earlier date, so long as it applies simultaneously to all such contracts and the fraternal gives the commissioner at least 30 days' notice of intention to adopt this section.

History: 1975 c. 373; 1979 c. 102 ss. 179 to 182, 237.

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. Sections 102.31 and 102.62 apply to worker's compensation insurance.

History: 1975 c. 375, 421; 1979 c. 102.